EXAMINING THE COSTLY FAILURES OF OBAMACARE'S CO–OP INSURANCE LOANS

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

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WITNESSES

SUBMITTED MATERIAL

EXAMINING THE COSTLY FAILURES OF OBAMACARE'S CO–OP INSURANCE LOANS

THURSDAY, NOVEMBER 5, 2015

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2322, Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Present: Representatives Murphy, McKinley, Burgess, Blackburn, Griffith, Bucshon, Brooks, Collins, DeGette, Castor, Tonko, Yarmuth, Clarke, Kennedy, Green, Welch, and Pallone (ex officio).

Staff Present: Jessica Donlon, Counsel, O&I; Emily Felder, Counsel, O&I; Brittany Havens, Oversight Associate, O&I; Charles Ingebretson, Chief Counsel, O&I; Dylan Vorbach, Legislative Clerk, CMT; Christine Brennan, Minority Press Secretary; Ryan Gottschall, Minority GAO Detailee; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Chris Knauer, Minority Oversight Staff Director; Una Lee, Minority Chief Oversight Counsel; Elizabeth Letter, Minority Professional Staff Member; and Arielle Woronoff, Minority Health Counsel.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Good morning. The subcommittee on Oversight and Investigation of the Committee on Energy and Commerce will come to order.

The subcommittee convenes this hearing today to examine yet another ObamaCare failure, the CO–OP Insurance Loan Program, the Affordable Care Act established Consumer Oriented and Operated Plans or CO–OPs, an experimental program that awarded government-backed loans to nonprofit health insurance issuers. Of the 22 CO–OPs that sold health insurance plans, unfortunately, 12 have failed to date. These failed CO–OPs represent $1.23 billion in Federal taxpayer money. Since CO–OPs must pay any outstanding debts or obligations before repaying the loan funds to CMS, it is unlikely that the Federal Government will ever recover these funds.

Originally intended to increase choice and create competition among insurers, these CO–OPs were structurally flawed and financially risky from the start. As early as 2011, HHS predicted that

36 percent of the loans would go unpaid. In 2012, the Office of Management and Budget projected taxpayers would lose 43 percent of loans offered through the program. The following year, an HHS OIG report expressed concerns about CO–OPs' financial stability and ability to repay loans. Even staunch supporters of the Affordable Care Act predicted the CO–OP programs would fail. Back in 2009, Senator Rockefeller wrote, quote, "There's been no significant research into consumer CO–OPs as a model for the broad expansion of health insurance." What we do know however is that this model was tried in the earliest part of the 20th century and largely failed. The Senator also called CO–OPs a, quote, "dying business model for health insurance," unquote.

Despite these widespread concerns CMS awarded $2.4 billion in Federal loans to 23 CO–OPs operating 23 States. This total does not include the CO–OP that failed before it enrolled a single person. CMS awarded a CO–OP in Vermont, over 30 million taxpayer dollars. However, in 2013, Vermont's State insurance commissioner denied the CO–OP a license, calling its application fatally flawed. The Federal funds that had already been spent to establish Vermont's CO–OPs, about $4.5 million taxpayer, were never recovered. The next CO–OP to fail was CoOpportunity, a CO–OP operating in Iowa and Nebraska. At first, CoOpportunity seemed to be a success. It enrolled over 120,000 individuals, which amounted to one-fifth of CO–OP enrollees nationally. However, CoOpportunity premiums were too low, and it was concerned about its ability to pay claims to providers. CoOpportunity received $145 million in Federal loans, but upon liquidation, it had operating losses over $163 million.

We are grateful today we will be joined later by Senator Ben Sasse, who had to run out to a vote on the Senate side. He will be here to talk about the CO–OP programs in Nebraska. Near the end of 2014, CMS awarded $315 million in last-minute loans to bolster six CO–OPs in dire financial situations, and of those six CO–OPs, three have since closed. It is doubtful that CMS will recover any of these additional funds.

Several factors have caused the CO–OPs to fail. In some cases, low enrollment was to blame. In other cases, CO–OPs set premiums too low. A July 2015 HHS OIG audit issued before the rush of CO–OP closures found that 21 of 23 CO–OPs incurred net losses. In 2014, it anticipated that low enrollments and net losses might limit the ability of some CO–OPs to repay loans.

Additionally, some CO–OPs have cited low-risk corridor payments from CMS as the reason for their demise because less money was paid into the risk corridor program than was expected. Insurers ended up with 12.6 percent of the payments they were anticipating. Given the CO–OPs' dismal financial situation, CO–OPs inappropriately hoped risk corridor payments would bail them out. However, the risk corridor program was always intended to be budget neutral. Only what was paid into the program would be paid out. In fact, in early 2014, a spokesman from CMS confirmed the risk corridor policy modelled on the risk corridor provision in Part D that was supported on a bipartisan basis was estimated to be budget neutral, and we intend to implement it as designed, unquote.

We are here today to understand what went wrong. We will hear from individuals who were on the ground implementing and regulating CO–OPs from day one. We will hear from State regulators faced with difficult decisions about how to best protect consumers in their States. We will hear from individuals who have established CO–OPs and the challenges they faced to balance CMS requirements in keeping CO–OPs afloat. We will hear from the auditors of CO–OPs. We will speak to the financial challenges CO–OPs face to pay back their Federal loans. And, lastly, we will hear from CMS about not only what went wrong, but how we can fix it with the goal of recovering taxpayer dollars awarded to the CO–OPs.

I thank all the witnesses for testifying today, and now magically appearing, the Ranking Member Diana DeGette.

[The prepared statement of Mr. Murphy follows:]

PREPARED STATEMENT OF HON. TIM MURPHY

The Subcommittee convenes this hearing today to examine yet another Obamacare failure: the CO–OP insurance loan program. The Affordable Care Act established "Consumer-Oriented and Operated Plans" or CO–OPs, an experimental program that awarded government-backed loans to non-profit health insurance issuers.

Of the 23 CO–OPs that sold health insurance plans, 12 have failed to date. These failed COOPs represent $1.23 billion in federal taxpayer dollars. Since CO–OPs must pay any outstanding debts or obligations before repaying the loan funds to CMS, it is unlikely that the federal government will recoup these funds.

Originally intended to increase choice and create competition among insurers, these CO–OPs were structurally flawed and financially risky from the start.

As early as 2011, HHS predicted that 36 percent of the loans would go unpaid. In 2012, the Office of Management and Budget projected taxpayers would lose 43 percent of loans offered through the program. The following year, a HHS OIG report expressed concern about CO–OPs' financial sustainability and ability to repay loans.

Even staunch supporters of the Affordable Care Act predicted the CO–OP program would fail. Back in 2009, Senator Rockefeller wrote: "There has been no significant research into consumer co-ops as a model for the broad expansion of health insurance. What we do know, however, is that this model was tried in the early part of the 20th century and largely failed." The Senator also called CO–OPs a "dying business model for health insurance."

Despite these widespread concerns, CMS awarded $2.4 billion in federal loans to 23 CO–OPs operating in 23 states. This total does not include the CO–OP that failed before it enrolled a single person. CMS awarded a CO–OP in Vermont over $30 million taxpayer dollars. However, in 2013, Vermont's state insurance commissioner denied the CO–OP a license to sell health insurance, calling its application "fatally flawed." The federal funds that had already been spent to establish Vermont's CO–OP-about $4.5 million taxpayer dollars-were never recovered.

The next CO–OP to fail was CoOportunity, a CO–OP operating in Iowa and Nebraska. At first, CoOportunity seemed to be a success. It enrolled over 120,000 individuals, which amounted to one fifth of CO–OP enrollees nationally. However, CoOportunity's premiums were too low and it was concerned about its ability to pay claims to providers. CoOportunity received $145 million in federal loans, but upon liquidation, it had operating losses over $163 million. We are grateful that Senator Ben Sasse is here today to testify about the failure of the CO–OP program, and how it has negatively affected Nebraskans.

Near the end of 2014, CMS awarded $350 million in last-minute loans to bolster six CO–OPs in dire financial situations. Of those six CO–OPs, three have since closed. It is doubtful that CMS will recover any of these additional federal funds.

Several factors have caused the CO–OPs to fail. In some cases, low enrollment was to blame. In other instances, CO–OPs set premiums too low. A July 2015 HHS OIG audit, issued before the rush of CO–OP closures, found that 21 of the 23 CO–OPs incurred net losses in 2014, and anticipated that "low enrollments and net losses might limit the ability of some CO–OPs to repay loans." Additionally, some CO–OPs have cited low risk corridor payments from CMS as the reason for their demise. Because less money was paid into the risk corridor program than was expected, insurers ended up with 12.6% of the payment they were anticipating. Given

the CO–OPs' dismal financial situation, CO–OPs inappropriately hoped risk corridor payments would bail them out. However, the risk corridor program was always intended to be budget neutral-only what was paid into the program would be paid out.

In fact, in early 2014, a spokesman from CMS confirmed, "The [risk corridor] policy, modeled on the risk corridor provision in Part D that was supported on a bipartisan basis, was estimated to be budget neutral, and we intend to implement it as designed."

We are here today to understand what went wrong. We will hear from individuals who were on the ground, implementing and regulating CO–OPs from day one. We will hear from state regulators faced with difficult decisions about how to best protect consumers in their states. We will hear from individuals who have established CO–OPs, and face challenges to balance CMS requirements and keep CO–OPs afloat. We will hear from the auditors of CO–OPs, who will speak to the financial challenges CO–OPs face to pay back their federal loans.

And lastly, we will hear from CMS about not only what went wrong, but how we can fix it—with the goal of recovering taxpayer dollars awarded to the CO–OPs.

I thank all the witnesses for testifying today.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Mr. DEGETTE. Thank you, Mr. Chairman.

I am sorry this important hearing has been impacted by the votes today because it is an important hearing. From day one I have worked with the State of Colorado and the administration to help our CO–OPs succeed. Across the country, the CO–OPs have provided consumer-focused coverage options and have injected competition into the health insurance market. Yet a number of CO–OPs are facing financial challenges and, unfortunately, will not be able to compete in the 2016 marketplace. We have all seen announcements in the last few weeks about CO–OPs closing their doors, including the CO–OP in my home State of Colorado.

I am very disappointed that the Colorado Division of Insurance was compelled to shut down the CO–OP. Yes, it faced challenges. But it also served the critical needs of 83,000 Coloradoans for 2 years, and the company was well on its way to fiscal sustainability in 2016. I am also disappointed at the way CMS has managed this problem, which I will get to later.

But you know something, equally to blame is us, Congress. I believe Congress has not worked as a partner to support the emerging CO–OP market that is attempting to bring more competition and choice to a market frequently dominated by one or two insurers. Mr. Chairman, I do wish that we had saved the CO–OP in Colorado, but if we can't do that, I hope we will use our time productively today to make sure the remaining CO–OPs are successful. Unfortunately, I know better than that. I know that a hearing before this subcommittee with the title Affordable Care Act or ObamaCare in the title somehow won't be a productive endeavor. We won't spend the next several hours learning from the experts before us about the challenges faced by the CO–OPs and what we can do to improve them. We could be doing meaningful oversight instead of taking 61 votes to abolish the Affordable Care Act. And, instead, my colleagues on the other side of the aisle prefer to sit on the sidelines and root for the law to fail.

Frankly, Congress has squandered the last 5 years by celebrating every bump in the road as we implemented the law, rather than focusing on how to make it better. Even worse, some of my col-

leagues have intentionally placed road blocks that have actually made it harder for their own constituents to access care.

Now, look, I am not suggesting the Affordable Care Act has been perfect, far from it, but I think that the important thing from these bumps in the road is to recognize the problems and to try to move the ball forward. If we could do that, we could work together to improve health care coverage for millions of Americans. In his op-ed, the Senator—I guess he is not going to testify—he said in an op-ed last weekend, quote, this isn't about spreadsheets. It is about people. And, frankly, I couldn't agree more. It is about people who, before the Affordable Care Act, faced skyrocketing health care costs. It is about people who were at the mercy of health insurance companies that could raise rates or deny coverage for arbitrary reasons to protect their profits. It is about people who feared that an unexpected medical cost would bankrupt them. But thanks to the Affordable Care Act, they don't have to face these uncertainties anymore. Americans are no longer one accident or illness way from financial ruin.

So, Chairman, our constituents should be able to depend on Congress to work productively in a bipartisan manner to improve the healthcare landscape in this country. That is what I hope to do today. I am going to use my time to hear from the experts before us about how we can make the remaining CO–OPs succeed. Frankly, as I said earlier, I have some hard questions for CMS. I want to know what went wrong with the risk mitigation mechanisms that were designed to promote competition and ensure stability in the insurance marketplace. I want answers about how the CO–OPs wound up owing money to the big insurance companies through risk-adjustment programs. I want to understand why CMS said over the summer that risk corridor collections would be sufficient to cover all risk corridor payments while less than 3 months later, they revealed they would only be able to pay 13 percent of the requested amounts to insurers. In short, I want to know whether CMS is thinking outside the box and coming up with a path forward to support this important competitive ingredient in today's health insurance market.

Thanks again to all of our witnesses for coming today. Thanks for waiting while we went to vote. I think you are going to be waiting again in a minute while we go back to vote, but your expertise will improve the law and the lives of our constituents. And I hope that members on both sides of the aisle have come ready to hear your ideas so we can finally have a productive hearing on the Affordable Care Act. I yield back.

Mr. MURPHY. Thank you.

Mr. McKinley is recognized for 5 minutes.

OPENING STATEMENT OF HON. DAVID B. MCKINLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA

Mr. MCKINLEY. Thank you, Mr. Chairman, and I agree with the lady from Colorado that this is about people. Failure of these CO–OPs have had real-life consequences. People are hurting. They are confused. The collapse of the West Virginia-Kentucky CO–OP leaves 56,000 policyholders frantically searching for new coverage

before the close of the enrollment period. Seven years ago, the coal industry in West Virginia was booming, and we enjoyed the seventh best unemployment rate in the country. But now fast forward to 2015, the unemployment rate is the worst in the Nation: 45 percent of our coal miners have lost their jobs in the last 3 years, and thousands more affiliated with the coal industry have lost their paychecks. These individuals and their families, they are hurting.

But they found a peace of mind in knowing that at least their family's health care was secure. Unfortunately, that comfort did not last long. Families enrolled in the West Virginia-Kentucky CO–OP have had that rug jerked right out from under them, all because CMS did not do its job and vet those CO–OPs properly or address the red flags that were raised after the Iowa-Nebraska CO–OP failed. Instead of hitting the pause button, the CMS continued to award $350 million in additional funding. Twelve of the 24 CO–OPs have already failed. At this hearing, I intend to ask now, who will be responsible for the medical bills that have been incurred by families all across? Who is going to pick up those costs when the CO–OPs are not there? Will CMS give flexibility to families confronting the crisis of their lost health care? What about with only one Statewide exchange available in West Virginia, one Statewide exchange? Failure of this CO–OP will now result in our families in West Virginia paying 120 percent higher premiums than they were last year. Is that fair?

This issue is not just about another failed ObamaCare program costing taxpayers in excess of billions of dollars. It is an opportunity for us in this room and in Congress to express our compassion and empathy for the hardworking families that have lost their sense of security. I look forward to the presentations today, and I yield back the balance of my time.

Mr. MURPHY. Dr. Burgess will take the rest of that time.

Mr. BURGESS. Thank you, Mr. Chairman, and thanks for the recognition. I think it is important that we are having this hearing today. There is a lot of policy in the Affordable Care Act. A lot of it was bad policy, and the CO–OP program is no exception. It has wasted millions of taxpayer dollars. It has suffered from a lack of oversight, and it has created instability for millions of patients. The model was fundamentally unsound from the start and was another example of the administration's desire to conduct dangerous experiments with our Nation's health care. Let us not forget that the ultimate patient protection is the assurance that their insurance carrier will not simply evaporate in the night, leaving patients without the coverage on which they rely. At last count, 12 of the CO–OPs have shut down, accounting for over a billion dollars in taxpayer dollars lost. The rate of failure continues to accelerate. In fact, the subcommittee staff struggled to finalize materials for this hearing because CO–OPs were failing and announcing failures faster than they could finalize the memoranda.

We will hear from witnesses today that the Center for Medicare and Medicaid Services continues to stand in the way of flexibility that the remaining CO–OPs need to become sustainable. We should not stand by as more and more taxpayer dollars are lost, more taxpayer dollars are invested in failed experiments, and millions re-

main at risk of losing their insurance as CO–OPs continue to close their doors.

So thank you, Mr. Chairman, and I yield to Mrs. Blackburn.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

I want to thank our witnesses. Especially I want to thank Commissioner McPeak from Tennessee for joining us. We are fortunate to have you in our state, and we are fortunate to have your guidance, and we look forward to what you will tell us about the failed CO–OP that we have had in our state. We also appreciate CMS taking the time to be here today. There are answers that we need as we conduct our oversight and due diligence on the system.

And, Mr. Chairman, I yield the time back to you.

Mr. MURPHY. Thank you. I now recognize Mr. Pallone for 5 minutes.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman.

When we passed the Affordable Care Act into law over 5 years ago, we dramatically changed the healthcare landscape in this country. The law has been a historic success. It has made access to comprehensive health care a reality for the American people. Before the Affordable Care Act was passed, the insurance system in this country was broken. It was a system with rapidly rising costs, gross inefficiencies, and painful inequalities. A February 2010 headline just a month before the ACA was passed declared, and I quote, "Soaring Premiums Reflect Unsustainable Health System." Up to 129 million Americans, nearly one in two people, could be discriminated against for a preexisting medical condition, ranging from diabetes to breast cancer to pregnancy. Many insurance plans lacked important benefits and limited coverage.

These things are no longer true. Because of the Affordable Care Act, people who were previously deemed uninsurable because of a preexisting condition are finally getting coverage. Today, insurers cannot cancel a woman's policy just because she becomes ill. Women are no longer discriminated against, and people who could not afford insurance before are now able to do so. The CO–OPs fill a critical role in this new post-ACA world. They put healthcare choices in consumers' hands. They prioritize their customers instead of their company overhead. They foster competition in the marketplace by bringing down prices. They do exactly what we had in mind when we passed the Affordable Care Act into law. And today's hearing should be an opportunity to examine how we can ensure the remaining CO–OPs succeed. We should be talking about how to infuse competition into the marketplace to bring premiums down. We should be figuring out ways to help our constituents have access to high-quality affordable health care.

But I am worried that is not what today is going to be about here. This committee has had dozens of hearings on the Affordable Care Act since it was passed into law, and those hearings have had only one purpose, to undermine the Affordable Care Act, regardless of how many people it is actually helping. These hearings have more often served to highlight only the flaws in the program, and

I look forward to you one day having a hearing, Mr. Chairman, where experts can talk about what is working, and there is much to applaud in that regard.

Moreover, we should be taking this opportunity to do valuable oversight. The Affordable Care Act oversight of the last 5 years has neither served to enlighten the committee nor improve the law. It has done the opposite. In short it is incredibly frustrating to hear Republicans criticize the law time and time again without offering productive ways to improve it and get better health care to more Americans who need it. With over 60 votes to repeal or undermine the law, I think the record is clear that most of the majority would rather root for failure than help move the law forward.

Finally, Mr. Chairman, I have suddenly heard many of my colleagues on the other side of the aisle lament that in the closing of the CO–OPs, many beneficiaries will now have to find new policies. Oh, my Republican colleagues are crying. Mr. Burgess in Texas, well, why don't you try to get the Governor and the State Legislature to expand Medicaid? That might help a lot of people. Or, Mrs. Blackburn, well, she didn't bring up TennCare today, but I usually hear about that. The fact of the matter is many of the people that signed up for the CO–OPs today had no insurance prior to their existence. Where were the voices of concern when people couldn't afford insurance or were uninsurable because their child had a preexisting condition? I think it is time to have a productive conversation about how we can improve the Affordable Care Act and the lives of all our constituents. Let this committee get to the place where it can work together to improve the law. I yield back.

Mr. MURPHY. The gentleman yields back. So they called votes. We are going to get through this as much as possible. We will swear you in, get your testimony. If you don't need the full 5 minutes, you don't have to give the full 5 minutes because we want to hear from you, and then we will come back and ask questions.

You are aware the committee is holding an investigative hearing and when so doing has a practice of taking testimony under oath.

Do any of you have any objections to taking testimony under oath?

They have all answered no. The chair advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do any of you desire to be advised by counsel today?

Dr. BEILENSON. [Nonverbal response.]

Mr. MURPHY. You desire to be advised by counsel. Could you identify your counsel, please?

Dr. BEILENSON. Steve Ross and Tom Moyer.

Mr. MURPHY. Will they be testifying?

OK, thank you.

Anyone else have counsel today? In that case, would you all please rise and raise your right hand. I will swear you in.

[Witnesses sworn.]

Mr. MURPHY. Thank you. You are now under oath and subject to the penalties set forth in Title 18, section 1001, of the United States Code.

We will start with Ms. McPeak, the insurance commissioner from Tennessee. You may give a 5-minute summary of your statement.

STATEMENTS OF JULIE MCPEAK, INSURANCE COMMISSIONER, TENNESSEE; JAMES DONELON, INSURANCE COMMISSIONER, LOUISIANA; PETER BEILENSON, BOARD OF DIRECTORS, NATIONAL ALLIANCE OF STATE HEALTH CO–OPS; AND JOHN MORRISON, VICE CHAIR, MONTANA HEALTH CO–OP

STATEMENT OF JULIE MCPEAK

Ms. MCPEAK. Thank you. Good morning, Chairman Murphy, Ranking Member DeGette, Representative Blackburn, and members of the subcommittee. Thank you for inviting me to testify. I am Julie Mix McPeak, commissioner of the Tennessee Department of Commerce and Insurance. In addition to my responsibilities in Tennessee, I serve in committee leadership roles at the National Association of Insurance Commissioners, and as executive committee member of the International Association of Insurance Supervisors, and as a member of the Federal Advisory Committee on insurance. I've spent most of my career in insurance regulation, previously serving as the commissioner of the Kentucky Department of Insurance. And I have a strong affinity for the country's State-based system of insurance oversight.

My testimony today will highlight the history of Tennessee's CO–OP, Community Health Alliance Mutual Insurance Company or CHA. My comments will focus on events this year that ultimately led to CHA voluntarily entering runoff on October 14. CHA was awarded $73.3 million in loans and advances from CMS to launch the company. CHA first offered plans on the federally facilitated marketplace in 2014, with plans in five of Tennessee's eight service areas. The company achieved minimal membership in 2014 due in large part to having plans priced significantly above the FFM leader and having limited network options. The company's membership and rate challenges were compounded by a population that was less healthy and sought more medical services than projected. CHA recorded a net loss of approximately $22 million at year end 2014.

In 2015, CHA saw its enrollment grow exponentially during the open enrollment period. And during the same period of time, projected medical costs continued to significantly increase. The department and CHA quickly recognized that such growth was too much too fast. Our department wrote a letter, which you have as exhibit 1, to HHS Secretary Burwell on January 8 requesting that HHS place an immediate enrollment freeze on CHA due to the company triggering the department's hazardous financial condition standard. The decision to freeze enrollment was and remains the right decision for the company and, most importantly, for Tennessee insurance consumers.

In mid-2015, the department conducted a thorough actuarial review of the company's proposed 2016 rates. After conducting our review, the department approved a rate increase of almost 45 percent for 2016. Throughout 2015, CHA peaked at more than 40,000 covered lives, but reducing down to almost 25,000 lives on the FFM where they remain today. Though we approved the rates to meet the CMS deadlines, we were not going to formally unfreeze the company until we reviewed initial results from a targeted financial examination called to evaluate the company's expenses, projections,

and financial viability, and until CMS released Federal final guidance on the risk corridor program.

In late September, the department was notified by CMS, and I think you have that as exhibit 2 to my testimony, that CHA was being placed on an enhanced oversight plan. That announcement was followed by risk corridor guidance that provided for significantly reduced risk corridor payments. The announcement immediately created a net worth deficiency for CHA. CHA asked the department if the $18.5 million startup loan could be counted as surplus if the loan terms were changed to be identical to the terms of the CMS solvency contribution. The department did not think that option was appropriate but told CHA—and I think you have that as exhibit 3—that statutory accounting principles would require the loan money to be classified as surplus if CMS and CHA bilaterally agreed to the loan agreement terms. After review at the department, CMS ultimately concluded that the loan conversion was not prudent. CHA voluntarily entered runoff on October 14. The Tennessee Department of Commerce and Insurance, CMS and its contractors, and CHA are working in close cooperation to ensure successful runoff. Our focus is on Tennesseeans first and foremost. My staff will continue to monitor the situation closely.

The runoff will continue well into 2016. And there may be additional surprises. But as of today, cooperation between the three entities has helped ensure a smooth transition.

Thank you for the opportunity to discuss the Tennessee experience with the subcommittee. I look forward to your questions.

[The prepared statement of Ms. McPeak follows:]

STATEMENT OF JULIE MIX MCPEAK
COMMISSIONER, TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE

BEFORE THE
COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

HEARING ENTITLED "EXAMINING THE COSTLY FAILURES OF OBAMACARE'S CO-OP INSURANCE LOANS"

THURSDAY, NOVEMBER 5, 2015

INTRODUCTION

Good morning Chairman Murphy, Ranking Member DeGette, Representative Blackburn and Members of the Subcommittee. Thank you for inviting me to testify before the Subcommittee this afternoon.

I am Commissioner Julie Mix McPeak. I am Commissioner of the Tennessee Department of Commerce and Insurance (TDCI). TDCI is comprised of several Divisions that regulate professions ranging from the insurance industry to local salons, and in my capacity as Commissioner, I also serve as the State's Fire Marshal. In addition to my responsibilities at home, I also serve in Committee leadership roles at the National Association of Insurance Commissioners (NAIC), as an Executive Committee Member of the International Association of Insurance Supervisors (IAIS), and as a Member of the Federal Advisory Committee on Insurance (FACI). I have spent most of my career in Insurance Regulation, previously serving as the Commissioner of the Kentucky Department of Insurance, and have a strong affinity for the country's state-based system of insurance oversight.

My testimony today will highlight the history of Community Health Alliance Mutual Insurance Company (CHA), Tennessee's Consumer Operated and Oriented Plan (Co-Op) under the Affordable Care Act (ACA). My comments will focus on 2015 events that ultimately led to CHA voluntarily entering runoff on October 14, 2015.

CHA INCORPORATION AND LOANS

CHA was incorporated on September 27, 2011, as a mutual benefit non-profit corporation authorized to transact business in the State of Tennessee. The Centers for Medicare & Medicaid Services (CMS) awarded $73,306,700 in loans and advances to CHA to launch the company.

Startup loans totaling $18,504,700 enabled the Company to begin operations and those loans were progressively funded by CMS between September 6, 2012, and December 20, 2013. Solvency contributions totaling $54,802,000 which serve to meet statutory surplus requirements were fully funded by CMS between March 4, 2013, and February 26, 2015.

2014

The first year for Co-Ops to operate on the Marketplace (Tennessee has a Federally Facilitated Marketplace (FFM)), as this Committee knows, was 2014. The FFM was new to all carriers and correct projections of rate and members were of utmost importance. Projections were particularly important for Co-Ops as they were new to the market with a limited amount of funds and federal limitations on the use of those funds. In the case of Tennessee, CHA had a trying first year of operations with significant expenses that exceeded minimal revenues.

In 2014, CHA offered plans in five (5) of Tennessee's eight (8) rating/service areas, including the

major metropolitan areas of Knoxville, Memphis, and Nashville. The company, like its sister company in South Carolina, entered the FFM solely with exclusive provider organization (EPO) plans. An EPO provides no out-of-network benefits.

In addition to offering EPOs where most other FFM carriers offered broader preferred provider organization (PPO) plans, CHA plans carried price tags that were approximately 20 percent higher than the FFM leader, BlueCross BlueShield of Tennessee (BCBSTN).

The company achieved minimal membership in 2014 in large part due to having plans priced significantly above the FFM leader and also due to having limited network options. CHA, at its high point in 2014, achieved several hundred covered lives in its FFM block of business.

The company's membership and rate challenges were compounded by a population that was less healthy and/or that sought more medical services than projected. In fact, CMS released guidance earlier on June 30, 2015, showing that Tennessee has the highest average risk score in the U.S. for the individual marketplace.

Low enrollment and poor experience for 2014 contributed to CHA recording a net loss of approximately $22 Million at year-end 2014. Those losses include business in the FFM, non-FFM, and group markets.

2015

Federal guidance required rates and forms to be approved mid-year 2014 for rates that would not be effective until January 1, 2015. That short window for CHA to decide 2015 strategy left it with little time to evaluate its incomplete 2014 experience before policies and rates were filed for 2015. The company invested in PPO plans and expanded its offerings to every rating/service area in Tennessee and planned to make itself more competitive by proposing a rating structure for 2015 that was largely based on where the market leader's plans were priced for 2014. Considering the Company's lack of credible experience to support its rating plan, the Department recognized proposed rates were likely inadequate. After discussions with CHA leaders, rates were ultimately approved by the Department at levels approximately 10 percent greater than the company had initially proposed.

CHA saw its enrollment grow exponentially during the 2015 open enrollment period and, during the same period of time, projected medical costs significantly increased. The Department, CHA, and CMS quickly recognized that the membership growth combined with its increased medical losses was too much too fast and our Department wrote a letter (Exhibit 1) to HHS Secretary Sylvia Burwell on January 8 requesting that HHS place an immediate enrollment freeze on CHA due to the company trigging the Department's Hazardous Financial Condition Rule. The freeze and corresponding suppression of CHA's FFM files went into effect on January 15, 2015. The decision to freeze enrollment was, and remains, the right decision for the company and most importantly for Tennessee insurance consumers. Throughout 2015, CHA peaked at more than 40,000 covered lives before falling down to almost 25,000 lives on the FFM where they remain

today.

2016

Proposed rates and forms for the 2016 plan year were due to the Department on May 15, 2015. The company, still under the freeze (which stayed in place for the remainder of 2015), recognized that it needed to request a significant rate increase to become a viable option for consumers in 2016. The company requested an average rate increase of over 32 percent and proposed pulling out of one rating/service area (Note: Under HHS guidance, this strategic company decision would not be considered a "market withdrawal" for 2016, but will in subsequent years for FFM carriers.)

After a thorough actuarial review that involved Department contractors and examiners, the Department approved a rate increase of almost 45 percent for 2016. We approved the rates tentatively expecting to unfreeze CHA in time for the November 1 Open Enrollment period. However, we were not going to formally unfreeze the company until we reviewed initial results from a targeted financial examination called to evaluate the company's expenses, projections, and financial viability, and until CMS released federal guidance on the risk corridor program.

RUNOFF

As CMS was pushing the Department for a response on unfreezing CHA for Open Enrollment, on September 29, 2015, CMS wrote to CHA (Exhibit 2) announcing its intent to place CHA on a corrective action plan (CAP) and on an enhanced oversight plan (EOP). The letter stated that

"...CMS has identified certain issues that threaten CHA's viability." and outlined several ongoing concerns, many of which CHA had been working to address with CMS.

A week later, on October 5, CMS released information on the risk corridor program that indicated that the percentage of payment for the 2014 plan year was only going to be at 12.6 percent, an amount significantly lower than the anticipated 100 percent. The inability of CMS' Risk Corridor Program to be fully funded created a net worth deficiency for CHA which ultimately could not be cured.

The Department recognized that a 12.6 percent payment percentage for 2014 made it highly unlikely that any amount will be paid out of the risk corridor program for the 2015 plan year, particularly because CMS still needed to collect over $2.5 Billion for 2014 before it moved on to 2015 and CMS risk corridor flexibility was limited by the Consolidated and Further Continuing Appropriations Act of 2015 (Cromnibus) that required the program to be budget neutral.

The Department then wrote to CHA on October 9, 2015, (Exhibit 3) requiring the company to develop a corrective action plan to rectify its solvency shortcomings that resulted from the company's $17,000,000 anticipated 2015 plan year risk corridor recovery that could no longer count towards company surplus after the CMS risk corridor announcement. Our letter required the plan to be acknowledged as acceptable to CMS if we were to approve it and allow the company to offer insurance policies on the FFM in 2016.

CHA's only ability to cure its net worth deficiency was to increase surplus with additional contributions. The Company asked the Department if the $18.5M startup loan could be counted as surplus if the loan terms were changed to be identical to the terms of the CMS solvency contributions. The Department did not think that option was appropriate but told the Company that Statutory Accounting Principles would require the loan money to be classified as surplus if CMS and CHA bilaterally altered the loan agreement terms. CMS, after review with the Department, ultimately concluded that the loan conversion was not prudent given the competitive market in Tennessee and the financial struggles at the company and refused to allow the loan to be recharacterized.

CONCLUSION

The Tennessee Department of Commerce and Insurance, CMS and its contractors, and CHA are working in close cooperation to ensure a successful runoff. Our focus is on Tennesseans first and foremost and the Company's current financial projections indicate that it has the resources to pay all claims that will be incurred through December 31, 2015, such that no consumer or treating physician is unfairly harmed.

The runoff will continue well into 2016, and there may be additional surprises, but as of today, cooperation between the three entities has helped ensure a smooth transition.

Thank you for the opportunity to discuss the Tennessee experience with this Subcommittee. I look forward to your questions.

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DEPARTMENT OF COMMERCE AND INSURANCE
500 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243-5065
615-741-6007

BILL HASLAM
GOVERNOR

JULIE MIX McPEAK
COMMISSIONER

January 8, 2015

The Honorable Sylvia Burwell
Secretary, Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Burwell:

As Commissioner of the Tennessee Department of Commerce and Insurance (TDCI), I respectfully request that the Department of Health and Human Services (HHS) place an immediate enrollment freeze on Community Health Alliance (CHA), a Tennessee-domiciled consumer oriented and operated plan pursuant to the Affordable Care Act (ACA). The immediate enrollment freeze and corresponding suppression of Federally Facilitated Marketplace (FFM) files is necessary due to the company's current tenuous financial condition.

On January 5, CHA provided TDCI with a December 31, 2014, projected Financial Statement, a December 31, 2015, Pro-forma Financial Statement, and other supplemental filings and projections. The Insurance Division reviewed the material and has found the company to be in violation of the Division's Hazard Rule (Chapter 0780-01-66, *Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition*, hereinafter "Rule"). The Rule lists various standards to consider in determining whether the continued operation of any insurer might be deemed to be hazardous to its policyholders, creditors or the general public. The Division based its decision in part on the following information.

- CHA expects to incur a $24.7M net loss for 2014 and its projected surplus at December 31, 2014 is $2.8M. The amount of the loss puts CHA in Hazardous Financial Condition according to our Rule. Pursuant to our Rule, any company that has a net loss in the last twelve-months which is greater than 50 percent of its remaining capital and surplus in excess of a $2M minimum is by definition in Hazardous Financial Condition.
- Company solvency is able to be maintained only because CHA plans to draw $34.7M against its available surplus loan balance, and recognize the draw in its 2014 financial statements. The amount of the draw was limited to the amount necessary to maintain surplus at 450 percent of RBC. This leaves the Company with approximately $20M in available solvency loans which it plans to completely draw and record in its 2015 financial statements. Even if the Company recorded the full amount of available solvency loans in the 2014 financial statements, it would still be defined by our Rule as being in Hazardous Financial Condition.

- CHA triggers the Rule because the insurer lacks adequate financial and administrative capacity to meet its obligations, as evidenced by its 130 percent combined ratio projected for 2015. Further, variable costs for claims and expenses exceed premium revenues in 2015 before even considering the Company's fixed overhead expenses.
- CHA projects an $11.2M risk corridor receivable which will be fully admitted as an asset in its December 31, 2015 financial statement. This is not guaranteed to be fully funded—this is "budget neutral" and "highly uncertain" for 2015 per Milliman, the company's consulting actuary. It is widely anticipated that these amounts may not be fully collected. As the final receipt of this amount is questionable, the Rule is violated because the collectability of receivables is uncertain. Without this asset, the Company's projections show that it would otherwise be insolvent by December 31, 2015.
- Based on its current (and growing) enrollment, CHA projects that it will have an RBC ratio of 228 percent at December 31, 2015, and a combined ratio of 126.2 percent for the year. This assumes the full risk corridor payment will be received. Even if this occurs, it will still trigger a Company Action Level Event in accordance with Tenn. Code Ann. § 56-46-104 (a)(1)(B), requiring CHA to prepare and submit an RBC Plan for corrective action to the Commissioner.

Though the current projections indicate the Company will be impaired (possibly insolvent) by December 31, 2015, there is still significant uncertainty about CHA's true current and future financial condition. The Company has continuously provided our Department with unreliable estimates of enrollment, medical losses, administrative expenses, and net income. The most recent estimates include a 100 percent increase in membership over the company's original estimates. The medical loss ratio estimates are now 18 percent more than the company's original estimates and administrative expenses are now 29 percent more than their original estimates. Unless and until we feel that reliance on CHA's estimates is justified, we must consider the possibility that these projections will also have adverse development.

In addition, TDCI has received a significant number of complaints in these first eight days of 2015 against CHA. The complaints address CHA not accepting premium payments, inadequate physician networks, and CHA's failure to pay agent commissions, among other things. TDCI is actively investigating these complaints, but is discouraged with the call volume. We question whether the company was adequately prepared to handle increased enrollment.

TDCI has been in communication with CHA and the company has requested an enrollment freeze. The Department agrees completely that an enrollment freeze is urgently required and will, in fact, require the company to cease enrolling new applicants. This action will not impact existing policyholders.

TDCI appreciates the time your team has spent with us to analyze CHA's financial condition and to assist in evaluating options to help protect CHA policyholders. Please advise regarding the soonest possible date that HHS can freeze CHA enrollment and suppress the related FFM files.

Sincerely,

[redacted]

Julie Mix McPeak
Commissioner

cc: Lourdes Grindal-Miller, Director, Division of Plan Management Policy and Operations
Kelly O'Brien, Director, Co-Op Division, Insurance Programs Group
Gina Zdanowicz, Director, Division of Plan Management Rate and Benefit

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

INSURANCE PROGRAMS GROUP

September 29, 2015

VIA ELECTRONIC MAIL: randmbramm@att.net
Mr. Ron Braam
Director and Chair of the CAP Oversight Committee
Community Health Alliance
445 S. Gay Street
Knoxville, TN 37902

Re: Corrective Action Plan (CAP) and/or Enhanced Oversight Plan (EOP)

Dear Mr. Braam:

On January 15, 2015, at the request of Tennessee Department of Commerce and Insurance (TDCI), the Centers for Medicare & Medicaid Services (CMS) placed an enrollment freeze on Community Health Alliance (CHA) health plans. On February 3, 2015, CMS placed CHA on a corrective action plan (CAP) citing hazardous financial condition (HFC), management deficiencies and member complaints regarding inadequate physician networks, failure to pay agents and brokers and acceptance of member complaints and CHA's failure to comply with section 7.1 of the Loan Agreement, which requires CHA to remain in compliance with all applicable Tennessee insurance laws and regulations. On April 30, 2015, CMS notified you that it approved your CAP.

In accordance with section of 11.1 of the Loan Agreement, CMS has continued to monitor CHA's performance in the CO-OP Program. As such, CMS reviewed required reporting such as your first and second quarter 2015 regulatory filings and pro forma financial statements and your 2016 rate filing. In addition, CMS conducted an onsite visit on July 10-11, 2015 and had several conversations with state insurance regulators.

Issues Identified by CMS

Based on review of the above information, CMS has identified certain issues that threaten CHA's viability. Specifically, CMS' assessment of your organization identified the following issues:

Financial Issues: CMS has concerns regarding CHA's financial viability because CHA is sensitive to any deviations from its financial projections due its 2015 year-end capital position. In addition, based on CHA's September 2015 pro forma financial statements, CHA is projecting a risk-based capital (RBC) level less than 500% for 2016. Thus, in accordance with CMS's

guidance released on December 9, 2014, CHA is in potential violation of Section 7.2 of the Loan Agreement, which states that surplus reserves held by Borrower cannot be more than 10% below the RBC level stated in the Business Plan (500%) for the applicable year at any time. Although your projection for 2016 is currently in compliance with the Loan Agreement, CMS is uncertain about your strategy to maintain the aforementioned requirement for RBC.

Operational, Compliance & Management Issues: CHA has experienced ongoing operational problems tied to issues with the processing of enrollment and downstream transactions by its vendor, Softheon. However, CMS acknowledges that CHA has made significant changes to address these ongoing problems, including:

- Creation of special teams to work with Softheon to address transaction processing issues;
- Increased member services support to respond to and resolve member, provider, and broker complaints and issues; and
- Development of a new software solution (Project Phoenix) to replace the Softheon vendor solution.

CHA shares its C-Suite and several administrative and operational personnel with Consumers' Choice Health Plan (CCHP). The two CO-OPs have entered into a Shared Services Agreement (SSA) that outlines how personnel responsibilities between CO-OPs and how employee costs are shared between the two CO-OPs. CMS shares the concerns raised by both CHA's and CCHP's board about the existing shared services agreement (SSA) and board governance and oversight processes, such as the proper allocation of resources, which include administrative infrastructure, IT infrastructure and vendor agreements. However, we acknowledge the actions taken thus far by CHA and CCHP to address these concerns which include creating a Shared Services Committee (SSC), which aims to re-evaluate the SSA, with recommendations expected to be implemented by June 30, 2016. However, CMS is uncertain of the recommendations approved by the SSC thus far, and is concerned with the effectiveness of your planned timeline.

CHA experienced high member, provider and broker complaint levels, driven, at least in part, by ongoing issues with the processing of enrollment transactions by it vendor, Softheon. The processing issues led to downstream problems in a number of other operational areas, including recognition of premiums, member access to care, and processing of provider claims. Other issues resulted from confusion on the part of providers who were unaware they were contracted with CHA through its integrated delivery system partners.

Competitive Environment/Strategy Issues

As of July 2015, CHA has 29,773 members and plans to increase its membership. However, CHA's health plans were under an enrollment freeze in 2015. Additionally, it is unclear what impact CHA's overall rate increase of 44.6% in the individual market will have on its membership.

CMS has concerns that these issues may impede CHA's viability. However, at this time, we believe these issues can be addressed by placing CHA on a CAP and an enhanced oversight plan (EOP).

CAP Requirements

The CAP must include a detailed plan describing:

- your strategy for resolution,
- key milestones,
- start and end dates, and
- proposed evidence of completion for each issue identified.

Failure to submit, obtain approval for, or successfully implement the CAP, or failure to achieve the required level of performance upon completion of the CAP, may result in termination of the Loan Agreement or other corrective actions as provided for in the Loan Agreement.

Specifically, the requirements of the CAP are the following:

1. Continue to meet the requirements of the current CAP;

2. Continue special operations and activities and the development of its new software solution to address ongoing Softheon-related transaction issues until a more permanent solution is fully implemented and validated;

3. Provide a detailed plan on how the "Project Phoenix" software solution will be fully tested and implemented by an appropriate time by October 30, 2015;

4. Provide a detailed contingency plan for transaction processing in the event "Project Phoenix" is not fully operational prior to open enrollment;

5. Complete CHA's consulting engagement to assess the existing shared services agreement. In the event significant changes are recommended, CHA should review required changes and provide developed plans for appropriate transition by January 30, 2015;

6. Provide a detailed plan that describes how CHA will continue to monitor complaint levels and sources of those complaints to determine whether the solutions implemented are addressing the appropriate root causes. If appropriate, CHA may need to consider continuing with the existing work-around and expanded member services to address ongoing operational issues;

7. Provide a detailed plan on how CHA will achieve its enrollment goals. The plan should also address the impact on CHA' enrollment goals if TDCI does not lift the enrollment freeze; and

8. Provide a detailed plan on how CHA will lower its administrative cost ratio (ACR) and meet CMS's 500% RBC requirement.

EOP Requirements

Based on the above information, CMS will increase its monitoring of CHA's financial viability by placing it on an Enhanced Oversight Plan (EOP). Accordingly, we require an explanation of CHA's plan to address the concerns referenced. To appropriately evaluate the financial risk posed

by CHA's current position. Under the EOP, you are immediately required to provide the following until further notice:

1. On a weekly basis, submit report that reflects CHA's progress in implementing "Project Phoenix" prior to open enrollment.

2. On a monthly basis, submit a report that reflects complaints received from CHA members. The report should reflect whether CHA has responded and/or resolved the complaint and how long it took to resolve the complaint.

3. On a bi-weekly basis, provide an update to CMS on CHA addressing the shared services agreement issues.

4. Submit Monthly/Cumulative Profit (Loss) Statement;

5. On a monthly basis, submit administrative spending vs budget; and

6. Submit monthly claims and loss ratio updates with detail including individual, small group, and large group lines of business.

The EOP requirements are critical to CMS's ability to evaluate whether CMS can remain confident that CHA will meet its obligations under the CMS CO-OP Loan Agreement. In accordance with section 16.2 of the Loan Agreement, a CO-OP's viability remains in the sole and absolute discretion of CMS. Thus, CMS may terminate your Loan Agreement if CMS receives additional information that indicates it is unlikely CHA will maintain a viable and sustainable CO-OP that serves the interests of its community and the goals of the CO-OP Program.

The CAP and EOP requirements requested in this letter are due to CMS no later than ten (10) business days from the date of this letter. Please contact Ms. Kathleen Scelzo at 301.492.4121 or Kathleen.Scelzo @cms.hhs.gov if you have any questions or concerns.

Sincerely,

[redacted]

Kevin F. Counihan
Chief Executive Officer, Health Insurance Marketplace
Director, Center for Consumer Information & Insurance Oversight

Cc: Julie Mix McPeak, Commissioner, Tennessee Department of Insurance
Gary Oakes, Chair, Board of Directors
Jerry Burgess, CEO, Community Health Alliance
Matthew Lynch, Insurance Programs Group Director
Kelly O'Brien, Director, CO-OP Program Division

Reed Cleary, Manager of the Finance and Risk Management Team
Meghan Elrington-Clayton, Manager, Policy and Program Integrity Team
Chanda McNeal, Manager, Operations Team
Kathleen Scelzo, CO-OP Program Account Manager
Joan Peterson, CO-OP Program Back-up Account Manager
Kitichia Weekes, Regional Account Manager

STATE OF TENNESSEE
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500 JAMES ROBERTSON PARKWAY
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October 9, 2015

Via Email

Jerry Burgess
Community Health Alliance
445 South Gay Street
Knoxville, Tennessee 37902

Re: Proposed Plan of Action Regarding Mandatory Control Level Event

Dear Mr. Burgess:

As you know, Community Health Alliance ("CHA") was found to be in hazardous financial condition in January of 2015 and CHA was frozen from accepting new enrollees at that point. CHA continues to be in hazardous financial condition as of the date of this letter and is still prohibited from accepting new enrollees. Further, on or about October 5, 2015, the Centers for Medicare & Medicaid Services ("CMS") of the U.S. Department of Health and Human Services ("HHS") released information regarding the risk corridor program for qualified health plans. This information indicated that the percentage of payout from the risk corridor program for the 2014 plan year was only at twelve and one half percent (12.5%), an amount significantly lower than the anticipated one hundred percent (100%). Considering this payout percentage for the 2014 plan year, it is highly unlikely that any amount will be paid out of the risk corridor program for the 2015 plan year. As such, statutory accounting will not allow the risk corridor recoverable to be counted as an admissible asset.

Prior to the updated risk corridor payout information, CHA booked one hundred percent (100%) of their approximate seventeen million dollar ($17,000,000) anticipated 2015 plan year risk corridor payment as an anticipated recoverable in their surplus. As this payout is no longer likely to occur, this amount cannot be considered as a part of CHA's surplus. As a result, the anticipated 2015 year end risk based capital ("RBC") percentage for CHA is approximately one hundred sixteen percent (116%). This low level RBC places CHA in hazardous financial condition pursuant to Tenn. Comp. R. & Regs. 0780-01-66. Furthermore, such an RBC falls below the mandatory control level RBC and triggers a mandatory control level event pursuant to Tenn. Code Ann. §§ 56-46-102 and 56-46-107.

Considering this new information, and the letter the Division received on or about September 29, 2015 from CMS stating that CHA is in a tenuous financial condition and that CMS questions CHA's viability, the Division requires CHA to develop a corrective action plan ("CAP") to rectify the RBC shortcomings to ensure viability of CHA for the 2016 plan year no later than October 12, 2015. The CAP should specifically address solvency concerns, operational concerns, and financial projections that demonstrate CHA's continued viability. The action steps outlined in the CAP should be acknowledged as acceptable to CMS before such CAP is submitted to the Department. When submitted, the Division will review and consider approval of the CAP. Please be aware, the submission of this CAP is not a guarantee that the Division will lift its previous determination that CHA is in hazardous financial condition. However, absent an **acceptable** CAP, as defined above, Tennessee law requires the Department to implement strict regulatory control over the company, which may include any actions contemplated under the provisions of Title 56, Chapter 9. The October 12, 2015, deadline is in consideration of the deadline imposed by federal guidelines and CMS guidance.

At this time, my paramount concern is to protect the policyholders of the State of Tennessee and ensure they are in no way harmed by any potential future insurer insolvencies.

If you have questions, please contact me at the above telephone number.

Sincerely,

[redacted]

Michael Humphreys
Assistant Commissioner for Insurance
Department of Commerce and Insurance
Davy Crockett Tower, 7th Floor
500 James Robertson Parkway
Nashville, TN 37243
michael.humphreys@tn.gov

Mr. MURPHY. Thank you.

I now recognize Mr. Donelon, the commissioner from the Louisiana Department of Insurance.

STATEMENT OF JAMES DONELON

Mr. DONELON. Thank you, Mr. Chairman and Ranking Member, for the invitation and the opportunity to be here today to speak briefly about our experience in Louisiana with the creation and now the demise of our CO–OP. Let me start at the outset by telling you a little bit about myself and emphasizing the point that I am here on behalf of my State of Louisiana and not as a representative of the National Association of Insurance Commissioners, though I am an active participant at that level as well, having served as its president during the year 2013. But I have been insurance commissioner in Louisiana since 2006 and was recently, last month, reelected for the third time, beginning my next 4-year term as we speak.

The creation of the Louisiana Health Cooperative, along with cooperatives in 23 states around the U.S., was a welcome part, from my perspective, although I have said repeatedly throughout my time as commissioner that if I had been here, I would have voted "no" on final passage of the Affordable Care Act for other concerns, but not for the opposition to the creation of CO–OPs. I saw that as a mechanism to address competition, which I believe is the most important aspect of consumer protection in my State, where my top insurer, Blue Cross, has 70 percent of the individual, small group, and large group market. My friends next door in Mississippi have a more dominant Blue than that, and the one next to them in Alabama is even more dominant, so that the well-intentioned purpose of the creation of these CO–OPs, to put consumers in control of an insurer and also to create more competition in our states, I welcomed at the outset.

Having said that, I now have described the effort to create insurers, health insurers, in the environment that existed as the rollout occurred of the Affordable Care Act, in hindsight, I have analogized it to being similar to learning how to sail in a hurricane. It truly was not possible, in my judgment, to succeed under those circumstances.

Much happened in my state that affected that. We licensed our CO–OP in April of 2013. And they began signing up enrollees in accordance with their loan agreement with CMS in October of 2013. That loan agreement called for them to sign up 28,000 lives. They ended up with 9,000 lives instead. In the several months between their approval and the beginning of their doing business, they had the challenges of the issues presented by guaranty issue, no lifetime limits, age caps, et cetera, not to mention the need for them to go out and rent a network of providers in a not very friendly to a purchaser of such service environment. They had to hire a TPA to do claims, to do their premium collection and payments on. They had to build a marketing network of agents, all of that in a relatively short, 5-month period of time that, frankly, in hindsight, was not functional.

The next challenge came with the rollout on June 30 by CMS of the transitional reinsurance program numbers and the risk adjust-

ment program numbers. And where the CO–OP would receive $10 million under the reinsurance payments, it would owe $7.5 million under the risk adjustment program. That represented a $5 million hit to their bottom line and triggered our calling them in on July 1, the leadership of our CO–OP, to tell them they should actually make the decision to go into runoff before the enrollment period began this October 1.

On July 7, their board voted to accommodate that request from our folks, and they began doing that. The Louisiana CO–OP's financial situation is dire. And we are doing everything we can to preserve its network of providers and to make sure that their policy holders will continue to have coverage through the end of 2015.

Now, us state regulators have the unenviable task, as I have, of trying to wind down a company while at the same time conserving it and doing so in my state, unlike Tennessee, without the protection of a guaranty fund to assure those healthcare providers that their bills would be paid. Let me talk for a few minutes about our relationship——

Mr. MURPHY. We don't have a few minutes. You're out of time.

Mr. DONELON. I'm out?

Mr. MURPHY. Yes.

Mr. DONELON. I'm sorry.

[The prepared statement of Mr. Donelon follows:]

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TESTIMONY OF THE LOUISIANA COMMISSIONER OF INSURANCE

Before the Subcommittee on Oversight and Investigations

Committee on Energy and Commerce

United States House of Representatives

Regarding:

"Examining the Costly Failures of Obamacare's CO-OP Insurance Loans"

Thursday, November 5, 2015

James J. Donelon
Commissioner of Insurance
State of Louisiana

Testimony of James J. Donelon
Commissioner of Insurance
State of Louisiana

Chairman Murphy, Ranking Member Degette, and Members of the Subcommittee, thank you for inviting me to testify before the Subcommittee on the issue of the Co-Op program, which will without question continue to garner headlines in the months ahead. I hope to share information that you may find useful and look forward to answering any questions you may have.

My name is Jim Donelon and I am Louisiana's elected commissioner of insurance since 2006. Prior to my election as commissioner of insurance, I served as chief deputy commissioner and executive counsel to the commissioner, and served for 19 years as a member of the Louisiana House of Representatives a significant portion of which I served as chairman of the House Insurance committee. I have been a very active member of the National Association of Insurance Commissioners, serving as president of the NAIC in 2013. I am not here today representing the NAIC, but rather the state of Louisiana as its chief insurance regulator.

The Co-Op Loan Program

Louisiana, like many states, has what many regulators might consider to be a non-competitive market for health insurance. In Louisiana, a single health insurance issuer has approximately 70% of all covered lives in all three of the fully-insured markets for major medical health insurance: individual market, small group market, and the large group market. There can be little doubt that the laws of economics are universal and fully applicable to the market for health insurance. A lack of competition can deprive consumers of choice and, potentially, value for their dollars. In addition, a single health insurance issuer having such a large market share can distort the price mechanism within other markets, not just the premium rates for health insurance. And so, it should go without saying that more competition is always better for consumers.

As a caveat, I must inform the committee that I have not shied away in the past from making my position clear: I believed in 2010 that the Affordable Care Act was not the ideal way to address the issue of affordability and accessibility for health insurance. Had I been a member of Congress, in your shoes, I would have voted against the Affordable Care Act. I have said for years that it was rushed through for reasons that all of you are aware of. Any of us who have served in a legislative body knows how hard it can be to whip votes against a clock. And the haste with which the Affordable Care Act was enacted is obvious not only from its numerous legislative fixes, but from administrative fixes that many of us have been hesitant to view as proper. Most importantly, I firmly believe that the regulation of insurance, all insurance, whether health or life or property and casualty, is best left to the individual states. Insurance markets have thrived in this country and they have done so under state regulation. State regulators and state legislatures know their states and their needs better than anyone, and they should continue to be the primary regulators and policy makers for the insurance industry.

Nevertheless, as a professional insurance regulator, it is my duty to enforce state and federal insurance laws. And despite my opposition to the enactment of the Affordable Care Act in 2010, I have endeavored to make sure that the law of the land is upheld. That's my job as an impartial regulator and my constitutional oath as an elected official. And with that in mind, let me say that the Co-Op program established under the Affordable Care Act was a well-intentioned idea. It no doubt had dual goals in mind of consumer-focused insurance companies because consumers were to be ultimately in control of the co-ops, and of increasing competition in the market for major medical health insurance.

The barriers to entry into the health insurance market are high. The start-up costs for entering that market are not easy to meet. Capital is not always plentiful or easy to come by. The destabilization of the market that has occurred in the wake of the Affordable Care Act, particularly the Market Reforms of Title I of the act, such as guaranteed issue and guaranteed renewability without medical underwriting and other rate limitations, has not made market entry look attractive. Indeed, in most states such as my own, more health insurance issuers have exited the market than have entered the market since many of the provisions of the Affordable Care Act have taken effect. For those reasons, any new entrant into the market will generally be looked at with eager eyes by an insurance regulator. The latest data from health insurance issuers bears witness to the difficulties that most insurers have had adapting to the Affordable Care Act's market reforms and limitations: more than half of health insurers suffered losses in the individual market in 2014 according to a McKinsey & Co. analysis of financial filings, despite a rise in the increase of total premium revenues over the prior year's data (2013). All of this to say: the Co-Op provision of the Affordable Care Act held promise, not only for consumers but for insurance regulators who want consumers to get more options and better value for their dollars. But the program that launched 23 start-ups did so at the worst possible time—a time when the market was in upheaval and uncertainty reigned, and to a significant extent, still does.

How the Co-Ops in operation, and those that were formerly in operation around the nation, turned out, has been a disappointment for state regulators and ultimately for consumers and tax payers. I am not here to criticize the Co-Op program, however. I am here to provide information from the perspective of a state insurance regulator who regulated Louisiana's health cooperative and who has now taken possession of the cooperative and placed into receivership, and ultimately, into liquidation. I will do so by addressing four key areas that staff and members have asked me to touch upon, and then by doing my best to answer whatever questions you may have.

1. The Demise of the Louisiana Health Cooperative, Inc.

The first issue I will give some information regarding is the failure of the Louisiana Health Cooperative, which was the second co-op to be subject to receivership activity by a state regulator following the seizure of the co-op operating in Iowa and Nebraska by my colleague and Iowa Insurance Commissioner Nick Gerhart. The Louisiana Health Cooperative was formed as a co-op under the Co-Op program of the Affordable Care Act and was licensed as a health maintenance

organization by the Louisiana Department of Insurance in May 2013, only about a year and a half away from the start of open enrollment for 2014—the first year that the market reforms of the Affordable Care Act were to take effect.

The Louisiana Health Cooperative had secured $13 million in start-up loans from CMS under the Co-Op program, and also secured millions more in solvency loans as its start-up capital. The total commitment from CMS under the Co-Op program to the Louisiana Health Cooperative was just shy of $65,800,000. From the start, the Louisiana Health Cooperative had difficulty preparing for the first open enrollment period in the fall of 2014, which was not overly surprising to us on account of the short time frame between licensing and open enrollment. At the conclusion of the open enrollment period for 2014, the Louisiana Health Cooperative had failed to meet its target enrollment, quite substantially in fact. The rates that were developed for the Louisiana Health Cooperative were designed to achieve certain economies of scale which obviously did not materialize. As a result, the Louisiana Health Cooperative suffered a $20.6 million loss in 2014, with an expense ratio of 35%, which was far out of line with the industry standard.

Furthermore, near the end of the 2014 calendar and plan year, the Louisiana Department of Insurance was alerted to the Louisiana Health Cooperative's failure to give timely notice to its enrollees that many of the existing 2014 health plans offered would not be renewed. Rather, enrollees would have to pick a new plan that would be offered by the Louisiana Health Cooperative, or the enrollees could pick a new plan offered by a different health insurance issuer. Both state and federal law requires at least 90 days notice for plan termination, which was to take effect on December 31, 2014. The Louisiana Health Cooperative, however, had failed to give notice until the first week of December 2014. Most enrollee plans were to terminate on December 31. As a result, enrollees needed to have a new plan in place for January 1. In order for anyone picking a health insurance plan through a federally-facilitated Marketplace, or Exchange, to have coverage on the firs of the month, an enrollee must pick a plan no later than the 15th day of the prior month. As such, by giving notice in the first few days of December, the Louisiana Health Cooperative had given its enrollees only about a week to pick a new health insurance plan. This failure was alarming to us.

During the same time frame, the number of consumer and health care provider complaints filed with the Louisiana Department of Insurance against the Louisiana Health Cooperative were also alarming. The Louisiana Department of Insurance has a process through which anyone, whether a consumer or a health care provider, can file a complaint with the Department of Insurance against a health insurance company, or any other insurer or licensed entity for that matter. Despite having approximately 2-3% of the total market share with its 12,000-15,000 enrollees, the Louisiana Health Cooperative was the target of 27 percent of all complaints received by the Louisiana Department of Insurance against health insurance issuers operating in the same markets in state of Louisiana. These two alarming issues, taken together, compelled state regulators to initiate a full on-site market conduct and financial examination of the Louisiana Health Cooperative beginning in March 2015, following internal preparations and analysis.

Later that same month, March of this year, the Louisiana Department of Insurance had determined that the Louisiana Health Cooperative had triggered several provisions of the state's Hazardous Financial Condition Regulation. The Louisiana Health Cooperative was informed of this on March 30, and was instructed to disclose its current business plan along with financial projections. By May, it was obvious that the Louisiana Health Cooperative had continued to suffer losses in the first quarter of 2015, but had balance sheets showing that the company still had minimum financial reserves required by law. That projection was based upon assumptions regarding monies that were to be received by the company from the premium stabilization programs of the Affordable Care Act, which you are hopefully familiar with—the Transitional Reinsurance Program, the Risk Corridor Program, and the Risk Adjustment Program. On June 30, 2015, after announcements by CMS, it was clear that the Louisiana Health Cooperative was to receive less money from two of these programs than it had projected. In fact, between the two programs, the Louisiana Health Cooperative would have to pay out a total of approximately $5.3 million. This unexpected payable produced a severe strain on the company's balance sheets. That day a team of regulators from the Louisiana Department of Insurance summoned senior executives from the company to a meeting the following day, July 1, 2015. At that meeting, our regulatory staff asked pointed questions about the company's viability, and suggested that the best result for enrollees would be for the Louisiana Health Cooperative to voluntarily wind down its operations over the remainder of the 2015 calendar and plan year, rather than risk insolvency in 2016 and force enrollees to find new coverage in the beginning of the 2016 plan year. Less than a week later, the board of directors voted to wind down the company's operations.

Throughout this time, the full examination of the company continued. During the course of the examination, the magnitude of the operational problems with the Louisiana Health Cooperative came fully into view. As a result, we reached the decision that in the best interests of the enrollees of the Louisiana Health Cooperative, the company needed to be placed into receivership so that the company's limited remaining resources could be conserved and be used to pay claims. We took that action on September 1, 2015. Now, the court-appointed receiver in charge of winding down the affairs of the Louisiana Health Cooperative has the unenviable task of simultaneously trying to wind down a company while trying to correct the many operational problems that contributed to its demise. The financial condition and the ability of the Louisiana Health Cooperative is of particular concern to us because in Louisiana, health maintenance organizations, "HMOs", which this company was organized as, is not subject to the Louisiana Life and Health Insurance Guaranty Association, and as a result, the company is not backed by that guaranty fund. This means that if the company cannot satisfy all of its claims liabilities, enrollees, and mostly health care providers could be stuck with unpaid bills. We are doing everything in our power to make sure that that does not happen.

2. The Relationship between the Louisiana Department of Insurance and CMS

Before I conclude my testimony, I have been asked, and assume you want to hear about the different roles of state and federal regulators that oversaw the Louisiana Health Cooperative. You have heard of the general activity of the Louisiana Department of Insurance as the company's chief

regulator. During our regulation of the Louisiana Health Cooperative, especially following the problems that the company had in giving timely notice of plan terminations to its enrollees at the end of 2014, the Louisiana Department of Insurance had constant and on-going contact with the Co-Op division of CMS, in addition to our permanent, working relationship with the Oversight Division at CMS, which was formerly headed by my colleague, Pennsylvania Insurance Commissioner Teresa Miller. The regulatory staff at the Louisiana Department of Insurance has a close, and effective working relationship with CMS. From January to June of 2015, my office was having constant conversations with officials at CMS in addition to contract examiners employed by CMS with respect to the Co-Op program. We had conference calls with CMS on a regular basis and beginning in June and July of 2015, we had multiple weekly conversations with CMS officials and sometimes daily interactions—all working together to try to determine what would be in the best interests of the company's enrollees. Regulators with CMS were candid in their assessments, shared information with us, and I do believe they viewed us as their partners in protecting consumers, which is one of our primary missions. Our examiners worked with CMS examiners, and in fact, we worked well together and reduced redundancies in the examination of the Louisiana Health Cooperative, which enabled us both to achieve a better picture of the company's operational condition faster than we might otherwise have been able to separately. The continuous contact and information sharing between CMS and the company now that it is in receivership has continued, and I believe, will continue to enable us to more efficiently and effectively wind down the company's operations.

Conclusion

In conclusion, I should like to say that the failure of the co-op in Louisiana and the failure of co-ops in other states, is not an indictment of nor a failure of competition in the market. I cannot speak to the causes of co-op failures in other states. But I can say that the co-op in my state did not fail because it was a co-op. Nor did it fail because the market was perfectly competitive. It is not. Our examination of that company has shown that it had other problems. Any company, whether a co-op under the Affordable Care Act or not, would face similar hazards in this market, especially following the destabilization to the market that the Affordable Care Act has caused. And, I say that not in the political sense, but in the undeniable sense that many of the reforms in Title I of the act have caused destabilization and unpredictability. In retrospect, perhaps it was not the ideal time to be a start-up in health insurance. To the extent that we have worked with CMS in the regulation of our Co-Op, my staff has found that the federal regulators at CMS were professional and proactive. But, as I always will before Congress, I conclude by saying that I continue to believe that the regulation of this industry is, again, best handled by state insurance commissioners.

Mr. Chairman, I did prepare a memorandum for the subcommittee and staff which I offer in support of my testimony.

With that, I conclude my testimony and would be happy to answer any questions you have.

MEMORANDUM FOR MEMBERS OF CONGRESS AND CONGRESSIONAL STAFF MEMBERS

FROM: JAMES J. DONELON, COMMISSIONER OF INSURANCE

RE: THE LOUISIANA HEALTH COOPERATIVE, INC.

This memorandum was requested by Congressional staff members in preparation for hearings to be held on November 5, 2015, by the Subcommittee on Oversight and Investigations of the House Committee on Energy & Commerce. The memorandum addresses four primary areas of concern:

1) A timeline of recent events and relative to the placement of the Louisiana Health Cooperative, Inc., (LAHC) into receivership;

2) The working relationship between the Louisiana Department of Insurance (LDI) and the Center for Medicare and Medicaid Services (CMS);

3) The operational and functional deficiencies of LAHC as viewed through complaint statistics and data; and

4) The issue of any remaining solvency loan disbursals and understandings from CMS regarding such disbursements.

This memorandum is prepared especially with regards to financial information concerning LAHC, with information that is accurate to the best of our current knowledge. Once the LDI finishes its "post-mortem" investigation into the failure of LAHC, a complete understanding of the reasons and circumstances of LAHC's failure will be possible. At the time of this memorandum, the primary concern of the LDI is to continue coverage for the approximately 15,000 enrollees of LAHC and to pay health care providers for enrollee claims.

I. Timeline of Recent Events & Receivership of LAHC

LAHC was licensed by the LDI on May 8, 2013, as a health maintenance organization (HMO) under Title 22 of the Louisiana Revised Statutes of 1950, the Louisiana Insurance Code. Under the relevant provisions of the Louisiana Insurance Code, LAHC had met the minimum qualifications, including the minimum financial requirements, to operate as an HMO in the state of Louisiana. For the sake of brevity, the timeline of events is limited to the recent period during which LAHC's financial deficiencies began to concern regulators.

The LDI experienced regulatory troubles (non-financial) with LAHC in the latter part of 2014 when the LDI discovered that LAHC had failed to give timely notice to enrollees of plan discontinuation as required by state and federal law; plan discontinuation in this

instance meant that LAHC was discontinuing certain health plans that had been sold for the 2014 plan year and were offering to replace those plans with new plans for the 2015 plan year. Although required to give enrollees 90 day notice of the discontinuation of current health plans, LAHC effectively gave enrollees just twelve days notice. The notices were sent to enrollees on December 3, 2014, informing enrollees that their health plans would be discontinued on December 31, 2014. Because enrollees must pick a new plan no later than December 15 to ensure coverage on January 1, LAHC left its members with just twelve days to pick a new health plan. On December 11, 2015, the LDI sent formal notice to LAHC that it would require LAHC to extend coverage into January on existing plans if enrollees did not select new coverage by December 15. This alarming breach of state and federal guaranteed renewability requirements, in addition to LAHC's inordinately high volume of consumer complaints then on file with the LDI, led then-Deputy Commissioner for Health Insurance Korey Harvey to request a market conduct examination of LAHC. After discussions with then-chief examiner Craig Gardner and Deputy Commissioner for Financial Solvency Caroline Brock, it was agreed that a financial and market conduct examination of LAHC would be appropriate in early 2015. After those conversations, LDI market conduct and solvency staff had internal discussions and preparations for the examination. The following timeline of events tracks those preparations.

Date	Description
2-13-15	LDI financial exam division informed LAHC about the upcoming LDI exam.
3-12-15	LDI financial exam division had an internal pre-exam meeting between all other applicable offices and divisions within the LDI to talk about LAHC and any pertinent issues. There were numerous items highlighted by the LDI Office of Health personnel related to complaints and the LDI financial analysis division personnel commented on the financial status of LAHC. LAHC had a net loss of $20.6 million in 2014, a combined ratio of 146% and an expense ratio of 35%. The expense ratio was much higher than the health industry standard which is around 12-15%.
3-16-15	LDI financial/market conduct exam commenced on-site at LAHC.
3-30-15	A Hazardous Financial Condition letter pursuant to Regulation 43 was sent to LAHC by the LDI financial analysis division. In the letter, standards A.2, A.5, A.6, A.14 and A.20 appear to have been triggered. LDI financial analysis division asked for a current business plan along with financial projections for the next two years.
4-8-15	LAHC management had a meeting with the LDI financial analysis division about the Regulation 43 letter than was sent to LAHC.
4-14-15	LAHC formally responded to the Regulation 43 letter related to Hazardous Financial Condition.

4-28-15	LDI Examiner in Charge (EIC) requested the preliminary 1st Quarter 2015 financial statements for LAHC on behalf of the LDI financial analysis division.
5-1-15	LAHC provided the preliminary 1st Quarter 2015 financial statements to the LDI on-site EIC. EIC provided the preliminary financials to the LDI analysis division as well as upper LDI Office of Financial Solvency management. From the financials, a net loss was shown of approximately $5.2 million. Capital and surplus was shown as approximately $9.1 million as of 3-30-15 compared to capital and surplus of $14.3 million at 12-31-14. However, LAHC personnel did mention that even though they were providing these preliminary financials, LAHC was still waiting on the first quarter Incurred But Not Reported (IBNR) and the 3R (Risk Adjustment, Reinsurance and Risk Corridor) information from their independent actuaries, Buck Consultants, and that the numbers could change. The 1st Quarter Statement was not due until 5-15-15. LDI Office of Financial Solvency was trying to be proactive and access critical data sooner rather than later to see if a potential insolvency was developing.
5-11-15	LDI Office of Financial Solvency personnel had an internal discussion about LAHC and its financial status between the LDI financial analysis and financial exam divisions. The purpose for the meeting was reviewing and discussing the preliminary 1st Quarter 2015 financials provided on 5-1-15. LDI General Counsel and LDI Deputy Commissioner of Office of Health attended as well.
5-12-15	LDI Office of Financial Solvency granted an extension to LAHC to file the 2015 1st Quarter Statement by May 22, 2015.
5-14-15	LDI Office of Financial Solvency granted an extension to LAHC to file the 12-31-2014 audited financial statements by July 31, 2015.
5-19-15	LDI Office of Financial Solvency granted another extension to LAHC to file the 2015 1st Quarter Statement by May 29, 2015.
5-29-15	LAHC provided the official 1st Quarter 2015 financial statement with the LDI. From the financials, a net loss of $968,000 was reported compared to the preliminary number provided on 5-1-15 of negative $5.2 mil. The capital and surplus was $13.3 million compared to $9.1 million provided on 5-1-15. LAHC provided a detailed explanation of the differences, which were related to IBNR and the 3R receivables calculated by Buck Consultants.
May-June 2015	LDI Life & Health actuary, Chief Examiner and EIC reviewed, performed analysis and discussed the paid claims data from 1-1-15 to 5-31-15. The IBNR hindsight testing and the completion factors used to project the ultimate paid claims for LAHC was showing that the IBNR reported for

12-31-14 was understated by approximately $6 million. In other words, the LDI Life & Health actuary was going to recommend an adjustment for the exam report of approximately $6 million to the 12-31-14 claims unpaid amount reported as part of the 2014 Annual Statement.

6-30-15 LAHC was informed by CMS that the Risk Adjustment receivable for 2014 and the Reinsurance receivable for 2014 would be materially different than what LAHC was reporting to the LDI. The net difference between the two categories was an approximate negative $5.3 million that LAHC had not been expecting to pay to CMS. LAHC management believed that they would receive net positive monies from CMS instead of paying into the premium stabilization program created by the Affordable Care Act.

7-1-15 LAHC management was called to the LDI for an emergency meeting with the LDI Office of Financial Solvency related to the CMS announcement on 6-30-15 relative to the Risk Adjustment and Reinsurance receivables. LDI Office of Financial Solvency management asked if LAHC would survive given the developing circumstances. LAHC management asked for time to discuss their financial position with the LAHC Board and then a response would be provided to the LDI.

7-6-15 LDI Office of Financial Solvency sent a letter to LAHC to ask follow up questions regarding the Regulation 43 letter that was responded to by LAHC on 4-14-15.

7-7-15 The LAHC Board decided to elect to voluntarily wind down LAHC operations and to not participate on the Federal Facilitated Marketplace (FFM) for 2016.

7-21-15 LAHC management came to the LDI to discuss the voluntary wind down plan.

7-29-15 LDI issued an Administrative Supervision Order, which limited LAHC's ability to conduct major transactions and certain special transactions without notice to the LDI.

8-3-15 LAHC contract attorneys provided the LAHC wind down plan and budget to the LDI Office of Financial Solvency.

8-5-15 LDI EIC, LDI Administrative Supervisors and Deloitte consultants representing CMS provided LAHC with a document as a response to LAHC's wind down plan submitted on 8-3-15. All parties wanted more in-depth responses than were submitted with the original wind down plan.

8-10-15 LDI EIC visited Group Resources, Inc., LAHC's TPA in Duluth, GA to review the TPA operations related to claims handling and member services. A Deloitte representative accompanied the LDI EIC on the trip.

August 2015 Numerous meetings were held between LAHC management, LDI personnel and CMS representatives (Deloitte). The meetings were related to the plan of action of winding down the operations and the financial projections concerning having enough cash to pay claims and other obligations.

In addition, discussions were held regarding converting the $13 million loan from a liability to a surplus note, and if LAHC would receive the other $9.25 million under the CMS loan agreement.

8-26-15 CMS notified LAHC management that LAHC's request to obtain additional monies under the loan agreement was denied. Also, the $13 million start-up loan was not going to be converted from a liability to a surplus note.

8-28-15 LAHC provided the LDI Office of Financial Solvency with a revised and more in-depth wind down plan than what was provided on 8-3-15. The plan was shared with CMS and Deloitte representatives, all of whom determined that LAHC should not continue to operate under its management.

9-1-15 LDI obtained a signed Receivership Order from the 19th Judicial District Court in Baton Rouge, LA, under which LAHC's management was terminated and LAHC was placed into the possession of the Commissioner of Insurance through the court-appointed receiver.

II. Working Relationship between the LDI and CMS

Prior to the state and federal guaranteed renewability violations detailed in Section I above the Co-Op Division of CMS regularly reached out to the LDI through its Office of Health Insurance to inquire if there were any state regulatory issues with LAHC that CMS should know about or could assist in resolving. Because of the close working relationship between state and federal regulators at CMS both in the Co-Op Division as well as in the Enforcement Division, the LDI was able to obtain immediate assistance from CMS when resolving the guaranteed renewability violations in December 2014. As the LDI geared up for its full examination of LAHC, the LDI made CMS aware of the impending examination and the two agencies agreed to share any pertinent information that might lead to examination determinations or results. From January through June 2015, the LDI and CMS held conference calls at least once a month to discuss both market conduct and financial examination results. By July 2015, the LDI, CMS, and CMS contract examiners, were holding conference calls at least twice per week and were communicating regularly via e-mail in between conference calls. Once LAHC was placed into receivership, LDI staff slightly reduced its participation in the twice weekly conference calls with CMS that are now lead by LAHC's receiver, Mr. Billy Bostick. The LDI regulatory staff continues to regard the CMS regulatory staff as consummate, professional regulators, and in the performance of their duties, they partnered with LDI regulators in the mission of enforcing the relevant provisions of the Affordable Care Act and protecting consumers.

III. Complaints against LAHC

A. Complaint Data from the LDI

Complaint data against LAHC has two primary sources: the LDI and LAHC. The LDI accepts consumer complaints of all kinds against any entity that it regulates (insurers, agents/brokers, third-party administrators, self-insured funds, etc., etc.) and processes those complaints in a manner aimed at resolving the complaint. Prior to a reorganization of the LDI in July 2015, all complaints against LAHC were handled by staff of the Office of Health Insurance, and since reorganization all complaints are processed by the Office of Consumer Services. Regardless of the date of a complaint or which office processed the complaint, all complaints are processed and tracked in the same manner. Under certain circumstances, including volume or repeated subjects, complaints may lead the LDI to commence either a market conduct exam or a financial exam of an insurer, or both.

LAHC was the subject of an inordinately high amount of consumer complaints to the LDI from January 1, 2014 through July 1, 2015. During that time frame, of the six major health insurers writing major medical business, LAHC was the target of 221 complaints, 27 percent of all consumer complaints despite having 1-3% of total market share of the individual and small group markets combined. No other insurer had achieved so great a disparity between market share and complaints during that time frame.

The primary reasons for the filing of consumer complaints with the LDI against LAHC since July 1, 2014 include:

1) Complaints by health care providers that claims for payment have not been made or not been made timely;

2) Complaints by enrollees of LAHC that the enrollees received termination notices for failure to remit premiums despite enrollees having remitted premiums and those premiums having been deposited into LAHC accounts;

3) Complaints by enrollees or their health care providers that prior authorization requests are not adjudicated timely;

4) Complaints by enrollees that they did not receive insurance cards and other enrollment materials following enrollment;

5) Particularly following the placement of LAHC into receivership, enrollees have complained that health care providers have refused to continue treatment of enrollees, although the court-appointed receiver has significantly ameliorated provider concerns and substantially reduced outstanding unpaid claims.

The five most frequent complaint issues recounted above all derive primarily from functional and operational deficiencies at LAHC that are linked to its operational management and its third-party administrator (TPA). LAHC engaged the services of a TPA that had limited experience with individual market health insurance administration, which is substantially different to administer than group health insurance. Additionally, the

TPA was unprepared for the volume of this vastly different administration required for individual market policies. Few health insurers process health claims through paper forms; most health claims are electronically transmitted from health care providers to insurers or their TPAs. However, approximately 80 percent of health claims from providers LAHC were received on paper forms per LAHC instructions to providers. This is not in line with widespread industry practice, nor was the practice by LAHC's TPA of manually adjudicating all claims. These two practices made it virtually certain that few claims by health care providers would be adjudicated and paid within the timeframe required by state law, which is a maximum of 45 days for non-electronic claims. Failure to timely pay claims subjected LAHC to statutorily-mandated interest payments to providers of 12 percent per annum. The LDI has the statutory authority and responsibility to regulate insurers with respect to Louisiana's prompt payment of health care provider statutes.

B. Complaint Data from LAHC

Separate and apart from complaints received by the LDI, LAHC also receives complaints from its enrollees and health care providers directly and from the federally-facilitated Marketplace (FFM) through its Health Insurance Casework System (HICS). The single largest reason for complaints since January 1, 2015, is issuer enrollment or disenrollment complaints, which constitute approximately 65% of all complaints received by LAHC. There is an enormous misalignment of data between CMS and LAHC's TPA, in addition to a lack of communication between the FFM technology and LAHC's technology as utilized by LAHC's TPA. The enrollment/disenrollment problems include members who allegedly enrolled but cannot be found in electronic systems, renewal failures, errors on CMS-created tax records, and other less frequent issues.

The primary reasons for enrollee complaints filed with LAHC directly and through HICS since January 1, 2015 include:

1) Complaints from enrollees that they have not been properly or timely enrolled;

2) Complaints from enrollees that they have paid their premiums but have not had coverage initiated;

3) Requests in the form of complaints from enrollees to have their coverage reinstated after wrongful termination;

4) Requests from enrollees to have their coverage terminated; and

5) Complaints from enrollees that their advanced premium tax credit was not properly calculated.

In addition to complaints from enrollees, LAHC separately tracks and processes complaints from health care providers. Since January 1, 2015, LAHC has received nearly 1,000 calls from health care providers. Despite the large number of calls, most calls centered on two primary issues:

1) Provider disputes (unprocessed claims; delayed prior authorizations; and claims re-pricing); and

2) Provider network issues (provider confusion over changes in LAHC's leased network of health care providers; issues over participating and non-participating provider status; confusion on where to submit claims, etc.).

IV. Financial Snapshot of LAHC and Future Solvency Loan Disbursements

Filed 2014 financial statements for LAHC in February 2015 based on information received from LAHC's consulting actuaries showed a net loss of ($20,665,020). This information also included a projected receivable through the Risk Adjustment Program of $2,799,840, the Risk Corridor Program of $2,112,537 and the Transitional Reinsurance Program of $4,948,537.

Monthly financial statements showing a loss of ($1,753,498.83) for January 2015 and a loss of ($161,311) for February 2015 were prepared for the LDI.

Shortly thereafter, LAHC received revised information from consulting actuaries for unpaid claims liability, projected commercial and Transitional Reinsurance, Risk Adjustment, Risk Corridor and terminal claims liability. This information included a projected increased amount to be received for Risk Adjustment, Risk Corridor and Reinsurance. LAHC increased Risk Adjustment receivables by $1,055,170 and increased Risk Corridor receivables by $2,082,662. LAHC also increased Reinsurance receivables by $1,444,506 for a total increase in receivables of $4,582,338. This resulted in a net income for the month of March 2015 in the amount of $946,600.

April 2015 financial statements showed a loss of ($1,160,575).

May 2015 financial statements showed a loss of ($879,639).

On June 30, 2015, LAHC received the actual numbers for Transitional Reinsurance and the Risk Adjustment Program. The report showed a receivable for Transitional Reinsurance in the amount of $9,878,052.34, which was a net increase of approximately $4,785,009. Risk Adjustment showed a payment due in the amount of ($7,493,608.15). This resulted in a difference of ($10,293,448.15) as of June 20, 2015. LAHC also received revised 2015 projected numbers from its consulting actuaries for the Risk Adjustment payable amount of ($5,800,413), Risk Corridor receivables in the amount of $4,389,192 and Reinsurance receivables in the amount of $1,713,666 which resulted in a total net loss for June 2015 in the amount of ($11,168,463.47).

July 2015 saw an increased claims expense and a decreased Advanced Premium Tax Credit (APTC) received due to decreasing paid membership which resulted in a total net loss for July 2015 in the amount of ($4,187,950).

August 2015 saw an increased claims expense and more decreased APTC received as well as an increased IBNR projection by CMS Consultants which resulted in

an increase of IBNR of $4,835,318. These differences resulted in a net loss for August 2015 in the amount of ($10,786,621).

In September 2015, LAHC received notification that the Risk Corridor receivables would be paid at 12.6% of expected receivables. With this information LAHC made the adjustment to reduce the Risk Corridor receivables to 12.6% of the amount expected for 2014 and removed the expected receivables for 2015. This resulted in a net decrease to Risk Corridor receivables of ($8,364,134) for both years. That change resulted in a net loss for September 2015 in the amount of ($7,270,740) for a Year to Date loss of ($36,422,199).

Billy Bostick, the court-appointed receiver of LAHC, had conversations with CMS officials on September 1, 2015. During those conversations, Mr. Bostick inquired if the remaining $9,250,000 in solvency loans committed to LAHC could be disbursed in order to satisfy LAHC obligations. In that conversation, officials with CMS assured Mr. Bostick that if a final disbursement were needed to satisfy obligations, the disbursement would be made. However, CMS would not agree to put that commitment in writing.

In addition to conversations with Mr. Bostick, CMS made several representations during the month of August to LDI Deputy Commissioner for Financial Solvency Caroline Brock that a disbursement could be made to satisfy LAHC obligations. Particularly, in one conversation in late August 2015 with officials of CMS, CMS made clear representations to LDI staff, including Ms. Brock, Deputy Commissioner for Health, Life, & Annuity Korey Harvey, and then-chief examiner Craig Gardner, that CMS would not disburse any remaining solvency loans if LAHC's present management remained in place. Due to LAHC's deteriorating financial condition and the lack of confidence that both the LDI and CMS had in LAHC's management, this conditioned representation provided the final impetus for the LDI to terminate its administrative supervision of LAHC and to formally commence receivership of LAHC.

Mr. Bostick intends to formally request disbursement of the remaining $9.25 million of solvency loans no later than November 2, 2015.

Mr. MURPHY. That's OK. Here's the thing. We have one vote. We also have Senator Sasse who is here, so the question is, we have one vote on the floor.

Ms. DEGETTE. Mr. Chairman, the problem is they are down to about 2 or 3 minutes left in the vote. And I don't think they're going to hold it open for us, unfortunately. So, with all due respect, I am going to ask my members to go down and vote.

Mr. MURPHY. So unless some person wants to remain, we are going to have to hold off. This will be very quick. So we'll run down, vote, and come back. So if members just do that, come back as quickly as possible, we should be able to reconvene in about 10 minutes. Thank you.

[Recess.]

Mr. MURPHY. We are joined here and bringing back in the junior Senator from Nebraska Senator Ben Sasse, who we understand taught Jeff Fortenberry everything he knows in Congress, so we are thankful.

Senator, you are recognized for 5 minutes.

STATEMENT OF THE HON. BEN SASSE, A SENATOR FROM THE STATE OF NEBRASKA

Senator SASSE. Chairman Murphy, Ranking Member DeGette, and members of the subcommittee. Thank you for inviting me to testify today. I appreciate the opportunity to think along with you about how we should respond to the failure of the CO–OPs in now 13 states. I am tempted to joke after that voting moment that two more CO–OPs have failed while you were off voting. It is an urgent problem that has left hundreds of thousands of Americans scrambling to find new health plans this fall.

Before we dive into the details on the CO–OPs, I would suggest that we should take our partisan hats off. I am a fierce opponent of the Affordable Care Act, and I know that many of you in this room night be strong supporters of the ACA, but I don't think that is what your hearing is about today. I think this is about getting to the bottom of what is actually going on and why so many of our neighbors are losing their healthcare coverage.

The tumultuous failure ACA's CO–OPs began in my own backyard. It began with CoOpportunity, which is actually headquartered in Nebraska but had a majority of its subscribers in Nebraska. The goal of today's hearing is to get to the bottom of what is happening with the CO–OPs, and I want to speak to two issues. First, while there is much more that we need to understand, what we know so far would suggest a systematic failure of the CO–OP program and an even greater example of bureaucratic incompetence more generally. Secondly, the lack of transparency on this issue is harmful, and the Department of Health and Human Services owes the American public answers.

Republican or Democrat our constituents deserve nothing less than a full accounting for what has happened with this program. The CO–OP program was included in the ACA to purportedly foster competition in the new exchanges by federally funding the start-up of 23 nonprofit health insurers. To get them off the ground, taxpayers loaned these insurers $2.4 billion. After less

than 2 years of operation, 12 of the CO–OPs are down and the program has a failure rate over 50 percent.

The first failure, CoOpportunity Health, as I mentioned headquartered in Iowa but with a majority of its subscribers in Nebraska, was arguably the messiest, because the members of the coopportunity program lost their health plan in the middle of a plan year.

CoOpportunity had been awarded it, $145 million of taxpayer-funded loans. The new insurer had garnered about 10 times the numbers of enrollees that they had originally anticipated and was seemingly successful. However, despite ample funding and, obviously, far more enrollees than anticipated, on December 16th of last year, 2014, about a month into the new open enrollment season, the Iowa insurance commissioner placed CoOpportunity under a supervision order. By January 23rd of this year, 2015, the Iowa insurance commissioner deemed rehabilitation of CoOpportunity impossible and sought a court order for liquidation.

After just one year of operation, the new not-for-profit health insurer abruptly collapsed. This was a terrible midyear shock to the 120,000 CoOpportunity enrollees, again, a majority of them in my State. These people were forced out of their insurance plans and had to go through the grueling process of signing up for coverage on healthcare.gov all over again with lots of uncertainty and fear about how their families might be covered or might not be covered during the transition.

So why did could CoOpportunity fail? Curiously, 9 months later, we don't really have any answers. Sadly, CoOpportunity's messy demise was just the first of the CO–OP dominos to fall this fall. Now, a total of 12 CO–OPs and 13 States will be closed by the end of this year. These 12 CO–OPs were awarded more than $1.1 billion in taxpayer-funded loans and had more than half a million enrollees. Another noteworthy failure is Health Republic of New York, the largest CO–OP in the Nation. It received more in taxpayer loans than any other CO–OP, totaling about $265 million. In late September, they announced they would be ceasing operations at the end of this year, but just last Friday, the State's health insurance regulatory body revealed that the situation was actually much worse than it had even been understood 6 weeks ago. Apparently, a review conducted in conjunction with CMS now finds that the previously reported filings were not an accurate representation of Health Republic's financial condition. Now, that CO–OP is planning to close down as fast as possible instead of being in business until the end of the year.

That means that more than 200,000 enrollees in Health Republic will have to pick a new insurer and plan in order to maintain health coverage for the month of December as well as planning for next year. Their new coverage, which they will now have to sign up for, will be expiring at the end of the next month, and then they will have to begin the process all over again of trying to find a health insurer.

The sudden disruption and subsequent consumer confusion is eerily similar to what happened to Nebraskans and Iowans earlier this year with CoOpportunity's closure. This brings me to a second point. We still don't have any good answers. With 12 out of 23 in-

surers rapidly going under, with inaccurate filings on the New York CO–OP, and with more than $1 billion in taxpayer loans out the door, there are more questions than ever, regarding the CO–OP program at large, and if they, those who are responsible for regulating it, knew what they were doing. I believe it is essential that HHS answer some basic questions, and all of us, Republican and Democrat, should be demanding that.

For instance, CMS awarded additional solvency loans to Co-Opportunity to Health Republic in New York and to the Kentucky Health Cooperative, all of which have since closed or are now closing, with CMS doubling down on their initial misjudgments by awarding additional loans. How did they decide to make these additional loans? Did they have any expectation that they were going to be paid back, or are they only going to be used to pay immediate claims?

At the time of these awards, these three insurers were operating at substantial losses that seemingly stemmed from poorly pricing their products. One analysis measured the percentage difference between the CO–OPs' average silver plan premium for a 27-year-old single person in the State, to the corresponding overall insurance market for all other carriers. Here's what they found. Co-Opportunity in Nebraska, Health Republic in New York, and the Health Cooperative of Kentucky were all pricing their products more than 20 percent below their competitors. How could this be possible?

Should HHS have given these companies more taxpayer money, given the anomalies of their pricing models? Moreover, HHS has yet to address if and when taxpayers will be repaid for any of the more than $1 billion that have been loaned to these 12 CO–OPs that have closed or are closing. These are the types of questions and the information that HHS should be providing to the American people through the Congress. Why are they not?

The lack of transparency thus far has been terribly disappointing. I started asking questions right after CoOpportunity failed in my State in May. Without receiving a sufficient response to my questions, I asked more questions when a second CO–OP, Louisiana, failed. By the time eight more CO–OPs had gone under, I elevated my effort to try to get answers to these questions. These are good governance, not partisan questions. I elevated my question by pledging that we will oppose the fast-tracking of all HHS nominations before the U.S. Senate.

Since that announcement less than 3 weeks ago, four more CO–OPs are closing, cementing further that this is a systematic problem, and still, we don't hear from HHS. Consumers who face this coverage disruption and the taxpayers who footed this bill deserve answers. CMS needs to provide a complete accounting of what has gone wrong within this program, and I hope that that starts today with your important hearing. Thank you for the invitation to testify.

Mr. MURPHY. I thank you so much, Senator.

[The prepared statement of Senator Sasse follows:]

Committee on Energy and Commerce Subcommittee on Oversight and Investigations,
"Examining the Costly Failures of Obamacare's CO-OP Insurance Loans"

November 5, 2015, 10:00 am

Statement from Senator Ben Sasse

As prepared for delivery:

Chairman Murphy, Ranking Member DeGette, and members of the subcommittee, thank you for inviting me to speak today. I appreciate the opportunity to think along with you about how we respond to the failure of CO-OPs in 14 states. It is an urgent problem that has left hundreds of thousands of Americans scrambling to find new health plans this fall.

Before we dive into the details about CO-OPs, I want to take a moment to suggest we take off our partisan hats. Yes, I fiercely oppose the Affordable Care Act. And yes, there are members of this committee who might love it. That's not what this is about. It's about getting to the bottom of what's going on and why so many of our neighbors are losing their health coverage.

The tumultuous failure of the Affordable Care Act's Consumer Operated and Oriented Plan program began in my own backyard with the collapse of CoOportunity Health in Nebraska and Iowa.

The goal of today's hearing will be to get to the bottom of what is happening with CO-OPs. I plan to make two points today. First, while there is much more that we must understand, what we know so far suggests that the CO-OP program may be systemically flawed and serves as an example of greater bureaucratic incompetence generally. Second, that the lack of transparency on this issue is harmful and the Department of Health and Human Services owes the American public answers. Republican or Democrat, our constituents deserve nothing less than a full accounting.

The CO-OP program was included in the ACA to purportedly foster competition in the new exchanges by federally funding the start-up of 23 non-profit health insurers. To get them off the ground, taxpayers loaned these insurers $2.4 billion. After less than two years of operation, 12 CO-OPs are down and the program has a failure rate of over 50 percent.

The first failure, CoOportunity Health in Nebraska and Iowa, has arguably been the messiest because people lost their health plan in the middle of the plan year. CoOportunity was awarded a total of $145 million in taxpayer-funded loans. The new insurer had garnered about 10 times the number of enrollees that they had originally anticipated and was seemingly successful.

However, despite the ample funding and enrollees, on December 16, 2014, more than a month into the new open enrollment season, the Iowa Insurance Commissioner placed CoOportunity under a supervision order. By January 23, 2015, the Iowa Insurance Commissioner deemed rehabilitation of CoOportunity impossible and sought a court order for liquidation. After just one year of operation, the new nonprofit health insurer abruptly collapsed.

This was a quite a shock to the 120,000 CoOportunity enrollees, a majority of whom are Nebraskans. These people were forced out of their insurance plans and had to go through the grueling process of signing up for coverage on healthcare.gov all over again.

So why did CoOportunity fail? Curiously, more than 9 months later, we still don't have answers.

But sadly, CoOportunity's messy demise was just the first CO-OP domino to fall. Now, a total of 12 CO-OPs across 14 states will be closed by the end of the year. These 12 co-ops were awarded more than $1.1 billion in taxpayer-funded loans and had more than a half a million enrollees.

Another especially noteworthy failure is Health Republic of New York, the largest CO-OP. It received more in taxpayer loans than any other CO-OP, totaling more than $265 million. In late September, they announced they would cease operations at the end of the year. But just last Friday, the state's health insurance regulatory body, revealed that the situation was much worse than originally anticipated. Apparently, a review conducted in conjunction with CMS found that the previously reported filings were not an accurate representation of Health Republic's financial condition. Now, the CO-OP is closing down as fast as possible instead of at the end of the plan year.

This means that the more than 200,000 enrollees in Health Republic will have to pick a new insurer and plan in order to maintain health coverage for the month of December. The new coverage will then expire on December 31st and they will have to once again choose another insurance plan for 2016 coverage. The sudden disruption and subsequent consumer confusion is eerily similar to what Nebraskans and Iowans faced earlier this year with CoOportunity's closure.

Which brings me to my second point: We still don't have good answers. With 12 out of 23 insurers rapidly going under, inaccurate filings for the New York CO-OP, and more than $1 billion in taxpayer "loans" out the door, there are more questions than ever regarding the CO-OP program at large. I believe it is essential that HHS answer basic questions.

For instance, CMS awarded additional solvency loans to CoOportunity, Health Republic in New York, and Kentucky Health Cooperative, all of which have closed or are closing now. Was CMS doubling down on their initial misjudgment by awarding additional loans?

At the time of the awards, these three insurers were operating at substantial losses that seemingly stemmed from poorly pricing their products. Indeed, one analysis measured the percentage difference between the CO-OPs' average silver plan premium for a single, 27-year-old in the state to the corresponding average premium for all other carriers selling in the same market and found that CoOportunity in NE, Health Republic in NY and Kentucky Health Cooperative were all priced more than 20 percent below all their competitors.

Should HHS have given these companies *more* taxpayer money given the anomalies of their pricing models?

Moreover, HHS has yet to address if and when taxpayers will be repaid for the $1 billion they loaned to these 12 CO-OPs.

These are the types of answers and information that HHS should be providing to the American people.

The lack of transparency thus far has been disappointing to say the least. I started asking questions after CoOportunity failed in my state this past May. Without receiving a sufficient response, I asked more questions when the second CO-OP failed in Louisiana. By the time eight CO-OPs had gone under, I elevated my effort to get answers by pledging to oppose all HHS nominations. Since that announcement, less than three weeks ago, four additional CO-OPs are closing, cementing further that this is a systemic problem within the CO-OP program.

Consumers who face coverage disruption and taxpayers who footed the bill deserve answers. CMS needs to provide a complete accounting of what has gone wrong within the CO-OP program. I hope that will start today at this hearing.

Thank you.

Local View: HHS owes Nebraskans simple answers

OCTOBER 31, 2015 11:57 PM • BY BEN SASSE

When CoOportunity Heath failed, 120,000 individuals — the majority of whom are Nebraskans — lost their health plans. They deserve to know what went wrong.

The several hundred thousand Americans who lost coverage when nine additional CO-OPs failed across the country deserve honesty, and taxpayers deserve transparency regarding the billions of dollars they loaned to these failed projects. Until we get those answers, the Senate should refuse to fast-track nominees to the Department of Health and Human Services (HHS), the agency responsible for overseeing this mess.

HHS owes Nebraskans clear answers. Here are the kinds of questions HHS needs to address. It's pretty simple:

* Did the people who ran these CO-OPs know how to make the numbers work?

* Why were these 23 CO-OPs given $2.4 billion, and where did the money go? How and when exactly were these decisions made?

* Was Washington throwing good money after bad by giving CoOportunity an additional $32 million just three months before it was forced to shut down?

* Can taxpayers expect to see the billions they loaned to these CO-OPs? Does HHS have any plan to make that happen?

* Did HHS know these failures were coming, and could consumers have been better protected? Was there a way to prevent the suffering that these families endured? Did HHS tell anyone that these problems might be coming?

We don't have those answers yet. In fact, some in Washington are claiming that these CO-OPs would have succeeded if only they had received more taxpayer money through a bailout known as the ACA's risk corridor program. If Congress allowed insurer bailout money, they argue, we wouldn't be in this mess. But here are the inescapable facts: First, CoOportunity was in serious financial trouble long before Congress clarified that there would be no bailouts. Second, as the Obama administration has said, this program was never designed to be an unlimited taxpayer-funded bailout.

Just how big is this problem? The Affordable Care Act's CO-OP program created 23 nonprofit health insurers across the country with $2.4 billion in taxpayer-funded loans. They began selling insurance in 2014 and, so far, 10 of them are already going out of business.

What about the others? Are they more successful? Hardly. A report from the HHS Office of Inspector General says only one of them was operating in the black at the end of 2014. This is a systemic failure.

Were these CO-OPS built on sound business models? It is possible that part of the problem was unsound pricing. For example, according to one analysis, CoOportunity priced its product more than 20 percent below the average silver plan premium of their competitors. The CO-OPs in New York and Kentucky have similar pricing compared with their competitors, and both are closing at the end of this year.

My office first asked questions after CoOportunity failed. We asked again when a second CO-OP in Louisiana went under. After eight CO-OPs had failed, we said that we'd oppose the nomination of new HHS nominees. Since we first asked, hundreds of thousands more Americans have been harmed by these failures and will face similar disruptions. Despite all this, HHS still refuses to explain what has happened.

This isn't about spreadsheets — it's about people. This is about the Nebraskans who lost coverage, the taxpayers who paid the bill, and the bureaucrats who sent out the checks.

Republicans and Democrats have a duty to our constituents, and HHS has a duty to provide these answers.

Contrary to the claims of some, demanding good governance isn't partisan — it's problem solving. We can only fix this mess after we've found the facts.

To date, HHS has refused to answer even the most basic questions. This is the agency that moved actuarial and solvency decisions further from the states — something they now appear to have no actual competence to execute. If Congress is going to prevent this from happening again, we need to understand exactly what went wrong.

Enough is enough. The victims — tens of thousands of Nebraskans and hundreds of thousands nationwide — who lost coverage deserve answers. The taxpayers who paid billions in loans deserve answers. Confirming new HHS nominees before that happens would be irresponsible and cruel. We have an obligation to get those answers.

Mr. MURPHY. I think you are going to be leaving now and head back over to the Senate. We do appreciate your insights and your persistence on this, and we want to continue to work with you.

Ms. DEGETTE. And let me just add, Senator. You didn't hear my opening statement, but I pretty much said the same thing as you did in terms of this should not be a partisan issue. We all need to figure out what's going on with these CO–OPs closing.

Senator SASSE. Congress needs to do better in oversight, not just in health care but in life in general. But that is a conversation for another day.

Mr. MURPHY. Thank you. All the best.

We'll now continue with our panel. Next up is Dr. Peter Beilenson. I got it right?

Dr. BEILENSON. Yes, sir.

Mr. MURPHY. The President, CEO, of Evergreen Health Cooperative. Doctor, you are recognized for 5 minutes.

STATEMENT OF PETER BEILENSON

Dr. BEILENSON. Thank you, sir.

Chairman Murphy, Ranking Member DeGette, and members of the subcommittee, thank you for inviting me to testify before you today. As the Chairman said, my name is Peter Beilenson, and I am president and CEO of Evergreen Health CO–OP, the Maryland-based CO–OP, founded in 2012. I also serve, as do all the CEOs of the CO–OPs, as a board member for the National Alliance of State Health Cooperatives, called NASHCO, and I appreciate the opportunity to appear before you today to discuss the issues affecting Evergreen and the other CO–OPs of NASHCO.

As several of you have already said, while many elements of the ACA have engendered significant partisan disagreement, the notion of establishing local consumer-driven and innovative healthcare options while enhancing competition on the marketplace should be appealing across the ideological spectrum. The question now that we confront with the remaining 11 CO–OPs is how can we succeed? How can they succeed? And how can taxpayer investment be preserved?

Unlike the difficulties experienced by many other state cooperatives in their first 2 years, Evergreen Health Maryland's current fiscal condition is strong due to our quick and nimble response to unforeseen conditions in our first year of operations. Going into the current open enrollment, which just started a few days ago, we have a healthier than average enrolled population, due to a diversified book of business; we have greater than $35 million in assets; we have risk-based capital, a measure of solvency adequacy of almost 800 percent, and for the last 3 months, each month we have been turning a profit. So this can be a profitable mechanism.

In addition, our strong relationship with Maryland Governor Larry Hogan's new insurance commissioner, Al Redmer, and his staff continues to provide us with significant support. Evergreen, like all other CO–OPs, take very seriously our obligation to pay back the loan funds granted to us by the Federal Government. However, several requirements in regulations developed by CMS and CCIIO at their discretion, not as required by provisions of the ACA, are significantly impeding the ability of the 11 remaining

CO–OPs, including Evergreen, to successfully innovate and compete with the few carriers left on each state's respective insurance markets.

In light of these concerns, I would like to highlight three solutions that could forge a successful path forward for the remaining CO–OPs. And let me be clear, these do not require an act of Congress; they do not require additional appropriations by the Congress.

First, as the CO–OP successfully market themselves and capture larger enrollments, they will need additional solvency dollars to continue to meet state regulatory requirements, put aside CMS's requirements. However, as you know, CMS has no additional funds to assist with the solvency needs of the growing CO–OPs. The solution to this issue is to allow individual CO–OPs to raise capital to meet these solvency needs. In fact, as you may remember, the ability to obtain private capital in Section 1322, which established the CO–OPs, was one of the measures by which the original CO–OP applications were judged. CMS should amend the loan agreements to allow flexibility in raising capital, because the restrictions on obtaining additional capital, are not required under the ACA Section 1322.

Second, risk adjustment under the ACA creates additional issues for the CO–OPs as formulas applied by CMS are skewed to the benefit of large preexisting insurers with enhanced administrative capabilities and years of claims experience with data for their members. The solution: CMS must revise the risk adjustment formula to create a level playing field for all carriers.

Third, and finally, the risk-corridor payments represent another issue for the CO–OPs. The solution: A swift resolution to the current funding deficit for this program will go a long way towards improving CO–OPs' balance sheets and long-term outlook.

Finally, we at Evergreen Health hope that both sides of the aisle and Congress will recognize that the nonprofit member-governed CO–OPs are trying to forge a new and innovative path for health insurance and give consumers increased choices in their coverage. This competition in consumer choice has had demonstrable effects. CO–OPs have brought innovative approaches to the marketplace and, thus, additional choices to consumers. For example, Evergreen Health offers a value-base insurance design product for diabetics, unique in the State of Maryland, which push the marketplace considerably, which removes virtually all financial barriers, co-pays, co-insurance, and deductibles to services, medications, and care that is needed to keep a diabetic patient from developing a myriad of complications of the disease.

In conclusion, I share the Congress' concern with protecting the Federal Government's initial investment in CO–OPs. The solutions I have proposed today, again, do not entail an act of Congress or any additional congressional appropriations. They simply require CMS, the Congress, and the CO–OPs to work together to make sure that the remaining 11 CO–OPs are preserved and that taxpayer dollars are preserved as well. Thank you very much.

Mr. MURPHY. Thank you very much, Doctor.

[The prepared statement of Dr. Beilenson follows:]

Testimony of Peter Beilenson, MD, MPH
CEO and President, Evergreen Health Cooperative
Board Member, National Alliance of State Health CO-OPs
Before the House Committee on Energy and Commerce
Subcommittee on Oversight & Investigations

November 5, 2015

Chairman Murphy, Ranking Member DeGette, and other Members of the Subcommittee, thank you for inviting me to testify before the Subcommittee today. My name is Peter Beilenson, and I am President and CEO of Evergreen Health Cooperative, a Maryland-based, non-profit Consumer Oriented and Operated Plan ("CO-OP") founded in 2012. As a leader of a state health CO-OP, I also serve as a board member for the National Alliance of State Health CO-OPs ("NASHCO"). I appreciate the opportunity to appear before you today to discuss the general issues presently facing Evergreen Heath and other healthcare CO-OP members of NASHCO in the current healthcare market and regulatory environment. However, I cannot speak with authority on specific matters related to any state CO-OPs other than Evergreen Health, which I believe to be one of the success stories of the CO-OP Program.

As you are aware, the CO-OP Program was established by Section 1322 of the Affordable Care Act, which initially appropriated $6 billion in loans to establish CO-OPs in each state. Subsequent budget cuts and other Congressional action reduced the loan funds to $2.4 billion, thus freezing the number of CO-OPs that could be funded at twenty-four. While many elements of the ACA have engendered significant partisan disagreement, the notion of establishing local, consumer-driven, and innovative healthcare options, while enhancing competition in the marketplace, should be appealing across the ideological spectrum. The question that we now confront is how to ensure that CO-OPs can succeed.

Unlike the difficulties experienced by many other state CO-OPs in their first two years, Evergreen Health's current fiscal condition is strong, due to our quick and nimble response to unforeseen conditions in our first year of operations. Following low initial enrollment due to significant operational deficiencies in Maryland's state health exchange and aggressive pricing by competitors in Maryland's individual insurance market, Evergreen Health quickly altered its business plan in 2014 to focus on the small group market. We priced our plans appropriately for the level of expected risk. Through competitive but actuarially sound pricing, well-designed plans, and supportive brokers, Evergreen Health achieved enrollment of 12,000 members by the end of 2014.

In more recent months, enrollment through Maryland's now-functional healthcare exchange, coupled with increases in our competitors' prices, have led to a

ten-fold year-over-year increase in individual enrollment for Evergreen Health in the most recent open enrollment period compared to the 2014 period. Small group sales have steadily increased, and we are now approved for—and have sold—large group plans (exceeding 50 members). All of these factors have resulted in an enrollment expected to exceed 30,000 by the end of 2015, and we expect to capture an even larger share of the individual market in 2016.

Going into the current open enrollment period, we have a healthier than average enrolled population, greater than $50 million in assets, and Risk Based Capital ("RBC"), a measure of solvency adequacy, of nearly 800%. In addition, our strong relationship with Maryland Governor Larry Hogan's new Insurance Commissioner, Al Redmer, and his staff continues to provide us with significant support.

Evergreen, like all other CO-OPs, takes very seriously its obligation to pay back the loan funds granted to it by the federal government, and the last thing anyone wants is for any more CO-OPs to fail without paying back their loans. However, additional solvency needs will create pressures for Evergreen Health and other state CO-OPs if certain current CMS requirements are not changed. Several requirements and regulations developed by CMS and CCIIO at their discretion, not as required by the provisions of the ACA, are significantly impeding the ability of the eleven remaining CO-OPs, including Evergreen, to successfully innovate and compete with the few carriers left in each state's commercial insurance markets. In light of these concerns, I would like to highlight solutions that could forge a successful path forward for the remaining CO-OPs.

First, CMS requires that CO-OPs maintain an arbitrarily high level of 500% RBC, despite state regulations in place to ensure the financial viability of other regulated insurers that require only a 200% RBC level in Maryland and many other states. Evergreen Health is therefore required to have 2.5 times higher RBC than all of its Maryland competitors. As the CO-OPs successfully market themselves and capture larger enrollment, they need additional solvency dollars to continue to meet the 500% RBC level. However, CMS has no additional funds to assist with the solvency needs of the growing CO-OPs. Although CMS has indicated that it will consider requests for waivers of the 500% RBC requirement on a case-by-case basis, CO-OPs have been told they will still come under increased oversight at 450% RBC.

A possible solution is to allow individual CO-OPs to raise capital to meet these solvency needs. CMS has recently indicated that they may entertain this potential solution, and it would seem to be an important step in the right direction. In fact, the ability to obtain private capital was one of the measures by which the original CO-OP applications were judged. CMS could amend the loan agreements, as this prohibition on obtaining additional capital is not required under ACA Section 1322.

Second, risk adjustments under the ACA may create additional issues for the CO-OPs, as formulas applied by CMS are skewed to the benefit of large, pre-existing insurers with enhanced administrative capabilities and years of claims experience data for their members (with some optimization processing perfected through insuring Medicare Advantage plans). Because many CO-OPs with particularly high enrollment took on a sicker, higher-cost insured population, it was anticipated that the ACA's "3 R's" (Risk Adjustment, Risk Corridor and Re-Insurance) would assist in securing their financial stability while caring for such a population. Yet, while many CO-OPs needed significant receivables through the Risk Adjustment Program, all but two of the 23 CO-OPs had significant *payables* due to the Risk Adjustment formulaic calculations.

In this sense, the administration of the Risk Adjustment Program has hindered competition in the healthcare market, especially as many large, pre-existing insurers were able to enroll their healthier populations in grandfathered policies—allowed by the Administration shortly before the start of Open Enrollment in 2014—and their sicker populations in QHP plans, thus scoring higher in risk adjustment on the individual and group lines of business and qualifying for greater assistance. Based on Evergreen Health's experience, the Risk Adjustment formula therefore requires review and revision to correct its disproportionately beneficial impact on larger carriers.

Third, Risk Corridor payments represent another potential issue for the CO-OPs. Although CMS has promised to eventually make all requested payments under the ACA's Risk Corridor Program, the CO-OPs have received little information regarding how these payments will be made, especially in light of certain statutory restrictions. The importance of these payments is much more immediate and acute for CO-OPs and other small insurers than it is for our large commercial competitors. A swift resolution to the current funding deficit for this program will go a long way toward improving CO-OPs' balance sheets and long term outlook.

Finally, we at Evergreen Health hope that Congress will recognize that the non-profit, member governed CO-OPs are trying to forge a new and innovative path for health insurance and give consumers increased choice in their coverage—enhancing competition that has been lacking in many states for years. This competition and consumer choice has had demonstrable effects on the markets where CO-OPs participate: in 2014, states with a CO-OP on the Federal Exchange had 6-9% lower rates than states without. CO-OPs also bring innovative approaches to the marketplace and thus additional choices to consumers. For example, Evergreen Health offers a Value-Based Insurance Design for diabetics, which removes virtually all financial barriers—co-pays, co-insurance, and deductibles—to services, medications, and care that is needed to keep a diabetic patient from developing the myriad complications of that disease.

In conclusion, I share Congress' concern with protecting the federal government's initial investment in CO-OPs. The solutions I have proposed today do not entail an act of Congress or any additional appropriations—I am simply asking for CMS to revise the Risk Adjustment formula to ensure fairness, to make promised Risk Corridor payments in full, to allow smaller insurers to effectively compete in the marketplace, and to eliminate CO-OPs' current barriers to obtaining additional capital—an ability that truly free markets provide.

Evergreen Health welcomes a working partnership with CMS and Congress to forge a successful path forward for the remaining CO-OPs. Thank you again for allowing me to testify today, and I look forward to your questions.

Mr. MURPHY. And now finally we hear from Mr. John Morrison, the vice chairman of Montana Health Cooperative. You are recognized for 5 minutes.

STATEMENT OF JOHN MORRISON

Mr. MORRISON. Thank you, Chairman Murphy, Ranking Member DeGette, members of the subcommittee. Thank you for inviting me to testify. My name is John Morrison. I was Montana's insurance commissioner, in 2001 to 2008, and I chaired NEIC's health insurance committee. I am the founder and past president of the National Alliance of State Health CO–OPs and vice-chair of the Montana Health CO–OP.

CO–OPs entered the marketplace in 22 States in 2014 and are now providing coverage to a million Americans. CO–OPs have brought much needed competition to the marketplaces, giving consumers more choice, introducing innovations and saving consumers and taxpayers money.

Montana, where I live, has a CO–OP. Wyoming does not. Both States are on the FFM. In 2013, Montana's average monthly premium was 18 percent lower than Wyoming. In 2015, with the Montana Health CO–OP in the picture, based on the second lowest silver plan, Montana is now 40 percent lower.

In 2014, states with CO–OPs had average silver plan rates 8 percent lower than states without CO–OPs. In 2015, among FFM states, the Delta was about 13 percent and over $500 per person for the year. Based on the roughly 3.7 million Americans enrolled in CO–OP states in 2015, consumers in those states have already saved more than the total cost of the CO–OP program.

Moreover, when rates are lower, subsidy costs to the Federal Government are lower. Taxpayers have already saved at least hundreds of millions in subsidies and would have saved billions over the decade ahead. One study published in Health Affairs, projected that if CO–OPs held rates down by just 2 to 5 percent, the savings to taxpayers over the next 10 years would be $7 billion to $17 billion. So the question is not how much CO–OP loans have cost the taxpayer. Rather, the better question is this, how much has the closing of CO–OPs and their removal from the marketplaces cost the consumer and the taxpayer for years to come? This question should be studied carefully.

So I thank you for holding this hearing today. Senator Kent Conrad recently said, the long knives came out to kill the CO–OPs in their cribs. We need to get to the bottom of this, as Senator Sasse said, and find out who killed these CO–OPs and how much Americans will pay for that mistake.

I got involved in the CO–OP project at the request of others, because I believe CO–OPs can break the endless inflationary spiral in our health insurance system. In my opinion, the following conduct of Congress and the administration has contributed significantly to the recent CO–OP closures.

One, the $6 billion in capitalization grants were changed to loans. Two, the CO–OPs were prohibited from using loan funds from marketing. Three, in 2011 when dozens of groups began meeting to turn the CO–OP concept into a nationwide reality, Congress slashed CO–OP loan funding from $6 billion to $3.4 billion. Four,

OMB directed CMS to cap CO–OP loans to prevent CO–OPs from achieving more than 5 percent market share. Five, in late 2012, 24 CO–OPs had signed loan agreements, and more than 40 additional groups were awaiting review.

Congress responded in the year-end fiscal cliff deal by rescinding the remaining lending authority and prohibiting CMS from authorizing additional CO–OPs.

Six, although CO–OPs had not yet opened their doors, congressional committees attacked them in hearings and press releases and tied the CO–OPs up with burdensome and expensive document demands.

Seven, CO–OPs reserve requirements were more than twice as high as other insures. Eight, existing insures were allowed to early renew their ACA noncompliant policies and preselected good risk, degrading the marketplace pool. Nine, CO–OPs were prohibited from offering necessary terms to outside investors to access private capital. Ten, in year one, CO–OPs were prohibited from limiting their enrollment on State exchanges and the FFM despite, limited capital.

Eleven, many CO–OPs were forced to pay risk adjustment to large existing carriers without consideration of the effect of early renewals or the CO–OP solvency requirements.

Twelve, most recently, Congress and the administration reneged on risk-corridor commitment, paying less than 13 cents on the dollar for 2014. For some CO–OPs, this was the fatal blow.

Americans will pay billions of dollars more in the years ahead, because these CO–OPs are closing. There are eleven CO–OPs remaining in 13 States. In my written statement, I make recommendations for measures that should be taken to maximize these CO–OPs' chance of long-term survival. I hope we can discuss some of these options today.

Thank you, and I look forward to your questions.

Mr. MURPHY. Thank you, Mr. Morrison.

[The prepared statement of Mr. Morrison follows:]

Testimony of John Morrison, Co-founder and Former President of the National Alliance of State Health CO-OPs (NASHCO)
Before the U.S. House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
November 5, 2015

Mr. Chairman, My name is John Morrison. I am the founder and past president of the National Alliance of State Health CO-OPs and Vice Chair of the Montana Health CO-OP. I served as State Auditor and Insurance Commissioner of Montana 2001-2008 and chaired the NAIC Health Insurance and Managed Care Committee. I serve on the boards of four health insurance companies. Although this is the first time I have testified about CO-OPs, it is the fourth time I have been asked to testify about health insurance issues and I have testified before committees in both the House and the Senate. I also serve as an expert to the U.S. Department of Labor regarding ERISA. I have been involved in the CO-OP project since before the Advisory Committee first met in early 2011. I became involved at the request of others, on a pro bono basis, because I believe that consumers need more choices in their health coverage and that CO-OPs have the potential to provide that additional choice.

CO-OPs Have Already Shown Promise in Expanding Choice and Increasing Competition

Consumer Oriented and Operated Plans were added to the Affordable Care Act in 2009 after the U.S. Senate scuttled the popular "Public Option" proposal. The rationale behind creating these non-profit, consumer-governed health plans was to infuse competition and innovation into the new Marketplaces, offer consumers an alternative coverage option, and prompt existing insurers to become more efficient and consumer focused. CO-OPs have started to deliver on all of those promises.

1. **CO-OPs defied expectations and overcame obstacles to cover more than a million Americans.**

CO-OPs entered the Marketplaces in 23 states in 2014 and, by mid-2015, were providing coverage to one million Americans. As Healthinsurance.org reported last month: "While enrollment in private plans through the exchanges increased by 46 percent in 2015 (from 8 million people in the first open enrollment period, to 11.7 million in the second open enrollment period), overall enrollment in CO-OPs increased by 150 percent."

2. <u>CO-OPs have increased competition and saved consumers and taxpayers money</u>.

In many parts of the country, CO-OPs provided a much-needed dose of competition to highly consolidated insurance markets. Consumers Mutual Insurance of **Michigan**, for example, has been the only carrier to bring meaningful competition to the Upper Peninsula of Michigan since anyone can remember; BCBS has dominated the market. The Michigan CO-OP was welcomed by all the hospitals and the insurance agents in the UP. Two thirds of CMI's 28,000 members are in the UP. Health Republic of **New Jersey** was the first new carrier to enter that market in 19 years. Without Community Health Options, Anthem would have been the only company on the **Maine** Exchange in 2014. The **Montana** Health CO-OP is one of three plans on the exchange in our state and accounts for 4 of 9 silver plans and 4 of 6 gold plans. These are just a few examples of the very real competition and choice that CO-OPs have brought to their marketplaces.

CO-OPs helped to increase price competition too. In 2014, states with CO-OPs had average silver plan rates 8% lower than states without CO-OPs. Montana, where I live, has a CO-OP. Wyoming does not. Both

states are on the FFM. In 2013, before the CO-OP began operating, the average individual monthly premium in Montana was $243 and in Wyoming, it was $297. Montana was 18% lower. Enter the CO-OP: In 2015, the second-lowest silver plan in Montana is $241 per month and the SLS in Wyoming is 407. Montana is now 40% lower.

In 2015, among all FFM states, the average premium in CO-OP states was $325 compared to an average monthly premium of $369 in states without CO-OPs - a delta of approximately 13%. That comes out to an average annual savings in CO-OP states of over $500 per person. With roughly 3.7 million Americans enrolled in CO-OP states in 2015 (according to acasignups.net), consumers in those states all told have already saved more than the total cost of the CO-OP program. *Moreover, when rates are lower, subsidy costs to the federal government are lower.* The taxpayers have already saved hundreds of millions in subsidies and would have saved billions over the decade ahead. One study published in *Health Affairs* projected that if CO-OPs held rates down by just 2-5%, the savings to taxpayers over the next 10 years would be $7-17 billion.[1]

[1] http://healthaffairs.org/blog/2013/07/08/countdown-to-the-health-insurance-marketplaces-four-actions-essential-to-success.

So, the question is not how much CO-OP loans have cost the taxpayer. Rather, the question is this: *how much has the closing of CO-OPs and their removal from the Marketplaces cost the consumer and the taxpayer*? This question should be studied carefully in order to guide future policy decisions. It appears that, even in their infancy, CO-OPs have already more than paid for themselves and would have saved taxpayers billions in the years ahead.

3. CO-OPs have offered innovative products and serve as change agents in the states where they are available.

All CO-OPs are nonprofit, consumer-driven health plans that focus, first and foremost, on the well-being of their members. CO-OPs' priorities include keeping people healthy, lowering premium costs, and delivering appropriate levels of care at the right time to keep members home and out of unnecessary hospital stays. Any profits are reinvested into expanded benefits and/or lower premiums for plan members.

CO-OPs approached the market with a different mindset than other insurers because they are governed by members and are truly non-profit. That mindset has motivated the CO-OP entrepreneurs to be

creative and implement exciting initiatives to change the game and bend the health care cost curve. For example:

- To incentivize quality care, **New Mexico Health Connections** developed a Shared Savings Program (SSP) with doctors' groups and health centers. The program compensates providers for participation in educational events, care coordination and reductions in the CO-OP's medical loss ratio.
- **InHealth Mutual** (Ohio) created a member portal for its Behavioral Health Depression Disease Management Program, providing members with daily opportunities to track their symptoms. The portal also contains a self-teaching program supported by behavioral health specialists to empower enrollees to better manage their health conditions.
- **Maine Community Health Options** has created a Chronic Illness Support Program. The program covers five prevalent conditions: diabetes, asthma, COPD, Cardiovascular Disease, and hypertension. It reduces the financial barriers associated with managing routine treatment of those diseases by eliminating co-

pays for office visits, generic drugs, durable medical equipment, and lab tests.

- Through an affiliate, **Evergreen Health** (Maryland) operates four patient-centered medical homes focused on coordinated care and wellness. Evergreen Health's model is a collaborative, team-based approach that fully integrates behavioral health with primary care.
- **Health Republic of New Jersey** implemented a harm-reduction program to use FDA approved medications to reduce smoking and promotes preventive services covering items such as colon cancer screening and biopsies.

Unfortunately, the residents of a number of states have now lost access to the important health care delivery innovations, alternative coverage options, and price competition that CO-OPs continue to make available in other states.

Multiple Factors Endangered the CO-OPs

A series of actions, including federal funding cuts made by Congress as part of budget agreements, changed the rules for CO-OPs in

the middle of the game and presented them with obstacles few small companies could overcome.

1. **Repeated funding cuts by Congress deprived the CO-OPs of capital.**

Opponents of reform hindered the CO-OPs from the outset to prevent them from fulfilling their mission.

In early 2011, dozens of community groups and insurance entrepreneurs, driven by a passion to reform America's broken health insurance system, began weekly phone meetings and formed a national alliance in order to turn the CO-OP concept into a nationwide reality. The CO-OP teams worked with private sector partners to develop business plans and submit loan applications to HHS. Seeing this, Congress slashed CO-OP loan funding from $6 billion to $3.4 billion. The Office of Management and Budget capped CO-OP loans to prevent CO-OPs from achieving more than 5% market share. CO-OP developers, unfazed, marched forward.

By late 2012, 24 CO-OPs had survived intensive public and private vetting and signed loan contracts worth $2 billion. More than 40 additional groups had submitted complete applications and were

awaiting review for a final round of CO-OP loan awards. To some, this outpouring of interest was not only unanticipated; it was unacceptable.

Congress responded in the 2012 year-end "Fiscal Cliff" deal by rescinding the remaining lending authority and prohibiting the Department of Health and Human Services from authorizing a single additional CO-OP.[2] Although CO-OPs had not yet opened their doors, Republicans in Congress attacked them in hearings and press releases and tied the CO-OPs up with burdensome demands.

Moreover, under federal regulatory requirements that the Department of Health and Human Services put into place, CO-OPs were required to meet higher insurance reserve requirements than other insurers and were prohibited from offering necessary terms to outside investors to access private capital, even as they were also prohibited from limiting their enrollment during the open enrollment period on state exchanges and the FFM. Simply put, CO-OPs were given the wood to build a boat for 50 people and then, in some cases, ordered to board 200 passengers.

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[2] See section 1857 of the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (P.L. No. 112-10), section 523 of the Consolidated Appropriations Act, 2012, (P.L. No. 112-74), and P.L. No. 112-240 § 644.

2. <u>CO-OPs did not receive the risk corridor funding they were promised.</u>

Congress recognized that the ACA would result in significant changes for all health insurers and that pricing in this new environment, where competition was based mainly on price, would mean high risk in the first few years. That is why the ACA included the temporary federal reinsurance and risk corridor provisions (in addition to the permanent risk adjustment program). The purpose was to mitigate the risk in these first few years until insurers better understood their markets. This was especially important to CO-OPs because they did not have any claims experience on which to base their premium assumptions, nor did they have large pools of existing capital to offset losses.

But in 2014, the risk-corridor program, in particular, came under fire from critics in Congress, who misleadingly called it a "bailout" for insurance companies and sought to defund or eliminate the program, even though the Medicare drug benefit includes a *permanent* risk corridor program.[3] Under intense pressure from critics, the Obama Administration announced last fall that the 2014 risk-corridor

[3] Paul Demko, "Reform Update: Partisan standoff looms over crucial risk-corridor payments," Modern Healthcare, October 24, 2014.

payments would be limited to the amount contributed by insurers, with any remaining payments owed to insurers for 2014 coming from future contributions. Congress then enacted a provision as part of the 2015 appropriations bill that prohibited HHS from using other available funding to make 2014 risk corridor payments. Despite repeated assurances from CMS that the risk corridor funds would be paid, which many CO-OPs and their actuaries accepted as true, the Administration recently announced the risk corridor would pay insurers less than 13 cents on the dollar. For some CO-OPs, this was the fatal blow. CO-OPs in Kentucky, South Carolina, Tennessee, Utah, Oregon, Colorado and Arizona attributed their closure to the reduced risk corridors. Deprived of tens of millions in promised revenue, barred from seeking equity investors, required to keep larger reserves than other insurers, and unable to control enrollment, one CO-OP after another announced it could not offer plans in 2016.

3. **The continuation of pre-ACA plans put CO-OPs at a competitive disadvantage.**

The Administration allowed insurers in many states to temporarily extend pre-ACA individual plans until as far out as 2017 – even though the plans failed to meet most of the ACA's market rules. In

states where insurers were permitted to extend these plans, the effect was a more segmented marketplace than the ACA envisioned and a risk pool for all ACA-compliant plans including CO-OP plans that was more costly than it would otherwise have been. While insurers that existed pre-ACA and continued to offer such plans could benefit from this "transition" policy, CO-OPs were not able to do so. All of their products were ACA compliant and they had no pre-selected good risk to balance the costlier Marketplace risk pools. The unfairness was compounded when many CO-OPs were required to write risk adjustment checks to the same insurers, which were complaining of poor experience in the Marketplace while excluding their better transition business from the risk adjustment formula.

4. **CO-OP pricing was reasonable, but all types of insurers have lost money in the marketplaces, and CO-OPs don't have the deep pockets to absorb the losses.**

The purpose of the exchanges was to stop the slicing and dicing of risk pools and to create a transparent marketplace where insurers would compete for business through price and service. CO-OPs have advanced this mission by competing and driving competition, but their rates generally were consistent with other competitive carriers. A

report done by McKinsey in the fall of 2013 showed that CO-OPs were usually not the lowest priced plan but were within 10% of the lowest price plan 42% of the time.

CO-OPs lost money in the first two years of the exchanges, but so did other carriers. For example, Health Care Service Corp., which owns Blue Cross Blue Shield companies in several states including Montana, reported that it lost $282 million in first year of ACA exchanges. Crane's Chicago Business (10/3/13) reported that HCSC deliberately priced aggressively in "a bold grab for more market share." Forbes magazine last month estimated that insurers overall lost $4 billion in 2014 on the exchanges due to underpricing. (A new McKinsey report puts the number at $2.5 billion.)[4]

No insurers like to lose money, but some are better able to absorb the losses than others. As *US News and World Report* wrote last week "[F]or-profit insurers remain resolute...because they have deeper pockets that allow them to wait out early losses while the exchanges develop. They also think the potential in this new market makes the wait worthwhile." The article notes, "Aetna, the nation's third-largest insurer, lost money last year on the exchange business, and it is losing

[4] http://www.wsj.com/articles/health-laws-strains-show-1446423498.

money this year too. But that business only amounts to about 6 percent of its operating revenue, and exchange enrollment makes up only 3 percent of its customer base of more than 23 million people." Aetna Chairman and CEO Mark Bertolini predicted he expects the exchange markets to stabilize over time and said they still represent a "big opportunity" for the company. The main obstacle Bertolini sees is that "the political environment in Washington doesn't currently allow for that type of compromise." [5]

Congress, the Administration, and State Regulators Must Act to Prevent Additional CO-OP Closings

The following steps, at least, should be taken to maximize the chance of success for the existing CO-OPs and increase the likelihood that Americans will have the opportunity to choose a CO-OP for their health insurance coverage:

A. Pay the risk corridor funds that were promised. These stabilization funds are critical to CO-OPs and other small carriers in this early stage of the Marketplace rollout. In the alternative,

[5] http://www.usnews.com/news/business/articles/2015/10/29/big-insurers-remain-upbeat-on-fledgling-aca-exchanges

immediately increase reinsurance program payments to make up the difference.

B. Convert existing start up loans for the CO-OPs to surplus notes so that they may become equity rather than debt on the balance sheet and restructure the loans over 15 years instead of five.

C. Redeploy remaining solvency capital and risk corridor payments of the closing CO-OPs to the surviving CO-OPs to ensure that they have enough risk-based capital to accommodate the consumer demand.

D. Give priority in risk corridor fund allocation to insurers that need the funds in order to meet RBC requirements.

E. Allow CO-OPs to establish a maximum enrollment before they enter the open enrollment period each year.

F. Fix the permanent Risk Adjustment program in the following ways: 1) Change the formula to reflect that existing carriers early enrolled business before the first open enrollment, gaming the system by making their ACA enrollment less desirable; 2) Provide that no carrier is required to make a full risk adjustment payment when it would threaten its solvency to do so; 3) Add to the formula other indicators of bad risk, such as prescription drug

utilization data; 4) Reduce the time lag that exists before risk adjustment determinations are available and speed up the consideration of the health conditions of new members; 5) reflect a "Care Coordination Factor" in the risk transfer formula; 6) Reflect relative plan efficiency instead of simply using the statewide market average premium in the risk transfer formula for all plans.

G. Allow CO-OPs to negotiate terms that permit them to access private equity capital.

H. Restore the CO-OP funding that has been eliminated and allow consideration of the CO-OP applications that were turned away when the program was terminated at the end of 2012. Fulfill the ACA's original objective of creating a CO-OP in every state.

Conclusion

The loss of CO-OPs that have been forced to close deprives the marketplaces of a much-needed catalyst for competition and innovation. It also costs consumers and taxpayers billions of dollars that would have been saved if the CO-OPs had been permitted to remain in business. The CO-OP closures were the direct result of repeated politically

motivated attacks designed to hobble them so they could not meet consumer demand for their products and could not have a competitive impact in the marketplace. An investigation of this matter is, indeed, appropriate. And Congress should do everything in its power to make certain that the remaining CO-OPs survive.

Mr. MURPHY. Let me start off with some questions here and I recognize myself for 5 minutes.

The CO–OPs and state regulators have cited many factors that contributed to the failure of the CO–OPs. Lower and hire expected enrollments, restrictions on investors, CMS blames risk adjustment formula, low risk corridor payments, lots of those. Let me start off, and Ms. McPeak, what are the top reasons that the CO–OP failed in your state?

Ms. MCPEAK. Thank you for your question, Mr. Chairman.

Our CO–OP had challenges from inception in that, as Commissioner Donelon mentioned, going into a state without provider networks caused the company to have to lease those. There were administrative costs that were due to the startup that any startup company would have. But then in 2014, we had disastrously low enrollment. Truly, at most, maybe 1,000 people signed up for the CO–OP plan. Mostly because the rates were somewhat higher than the FFM leader, a well establish a company in the State of Tennessee.

So overcoming those challenges became extremely difficult, and that's why we saw significant rate increases for 2015 and beyond because of the enrollees across the market and Tennessee. We had higher than expected utilization, high claims costs, and insufficient premiums.

Mr. MURPHY. Did the other plan also lose money, then, too when they had lower costs for the premiums?

Ms. MCPEAK. Yes. Actually, every plan on our federally facilitated marketplace on the exchange lost——

Mr. MURPHY. That's what I understand. Kind of nationwide, whether they would cost others in the bid to get enrollees, they had to underbid, and then we find out many of them realized the next year, they had to make up for the losses by charging more. And some survived and some didn't.

Ms. MCPEAK. That's our experience in Tennessee. We didn't have any company accurately project the claims costs that were going to be coming from these enhanced benefit plans that were sold in the state and mandated under the Affordable Care Act. And so some of our larger established companies could withstand those companies and offer plans, but the CO–OPs just didn't have those resources available.

Mr. MURPHY. Dr. Beilenson and Mr. Morrison, what would you say are the top reasons that 12 out of the 23 CO–OPs failed? I think, Mr. Morrison just read off a list, but internal problems too, so not just external. But, Dr. Beilenson, do you have some insight into what are the top reasons why they failed?

Dr. BEILENSON. I don't really know specially what happened with the other groups, although the risk corridor was clearly an issue and as John said, the risk adjustment was a big issue as well, because they were surprising payments instead of receivables on risk adjustment and vice versa on risk corridor.

Mr. MURPHY. Mr. Morrison?

Mr. MORRISON. I don't mean to suggest that there were no mistakes made by management in CO–OPs, but if you look across the marketplace, what you see is that this was a very competitive marketplace, and insurance companies all priced aggressively. Every-

body lost money. The difference was that CO–OPs were new entrants. They did not have other business and surplus to be able to offset the losses, and their capital was continuously reduced and capped.

So when Commissioner Donelon talks about learning to sail in a hurricane, that's especially apt in a situation where we were prohibited from building a big boat, and we were not only put into a hurricane, but in some cases given money to build a boat for 50 people——

Mr. MURPHY. As the rollout occurred, we heard this, whether it was the Web site or other aspects, too, there was just not a lot that was clearly thought out. It was rolled out, pushed out and maybe is more like it. I know with the Web enrollment and other things, which we found out wasn't ready, they knew wasn't ready. Would you say it wasn't ready when this started up? Should more foresight have gone into setting this up before the CO–OPs were thrown into the hurricane?

Mr. MORRISON. To my knowledge, there has never been the situation where 22 new health insurance companies entered the health insurance market across the country in the same year, 2 years after they chartered their business. And so that was certainly a challenging situation. But it was much more challenging, and indeed, fatal for some, because they did not have adequate capital to deal with the risks that they were put into.

Mr. MURPHY. Mr. Donelon, can you comment on that, too, how in your state that happened?

Mr. DONELON. Absolutely. Thank you.

Mr. MURPHY. Microphone.

Mr. DONELON. I'm sorry. Thank you, Mr. Chairman. And again, thank you for the invitation to be here today. My situation was even worse. We were one of the last CO–OPs to be approved before the termination of the program.

And so the timeframe from licensing in May to selling in October was so constrained that building our company was quite a challenge. I was initially very encouraged, because the group that got approval from CMS for CO–OP loans and from us for licensing, was closely associated with our optional health plan back in New Orleans. A maybe 100-year-old hospital and clinic operation, internationally respected and had been in the health insurance business until the 1990s when they sold off their health plan to Humana. So with their credibility and their experience and expertise, I was hopeful and optimistic that we'd be successful. In hindsight, it was too much in too short a period of time, plus all the other problems that have been described here in testimony today.

Mr. MURPHY. Thank you.

Ms. DeGette is recognized for 5 minutes.

Ms. DEGETTE. Well, this is what I was talking about in my opening statement, because the ACA started in 2010, then these CO–OPs started a couple of years later, and then they had a couple of years to get going. So it wasn't like we were trying to stand up 22 companies all at the same time we were doing the enrollment on the Web site and all that. This was staggered. Is that right, Mr. Morrison? Yes or no will work. It wasn't all at the same time?

Mr. MORRISON. The awarding of the loans was staggered.

Ms. DEGETTE. Right.

Mr. MORRISON. That's true.

Ms. DEGETTE. So really, part of the problem we have—yes, there were problems with the capitalization from the beginning, but part of the big problem is that there was no support as it went along. Wouldn't that be a fair assessment?

Mr. MORRISON. Inadequate capital was the problem.

Ms. DEGETTE. Right. That's what I want to talk about. The CO–OP program was initially conceived as a grant program, but then the startup funding ultimately ended up being in the form of loans; is that right?

Mr. MORRISON. Yes.

Ms. DEGETTE. And then Congress cut the CO–OP loan funding program from $6 billion to $3.4 billion; is that right?

Mr. MORRISON. And then to $2.4.

Ms. DEGETTE. Right. And then in the 2012 fiscal cliff deal, Congress—which by the way I voted against, Congress rescinded the remaining lending authority for CO–OPs, which essentially blocked the establishment of further CO–OPs even though 40 additional groups had submitted applications; is that correct?

Mr. MORRISON. Very correct.

Ms. DEGETTE. Now, irrespective of that, 23 CO–OPs got established. And the CO–OPs, like all the other insurers in the health marketplaces, took into account the Affordable Care Act risk stabilization programs, to help insurers mitigate the risk of insuring new populations who had potential losses, the law offered the 3Rs; the reinsurance, risk adjustment, and risk quarter programs, but those don't seem to have worked.

So I wanted to ask you, Dr. Beilenson, the risk adjustment formula has been problematic, as we've been discussing. In fact, a lot of the small CO–OPs are writing checks to large insurance companies under the risk adjustment formula. Does that seem fair to you?

Dr. BEILENSON. It does not. And it was actually 21 of the 23 that were writing checks.

Ms. DEGETTE. Twenty-one of the 23 writing checks to big insurance companies.

I also understand because of Congress' rule of budget neutrality, the risk-corridor program has failed to help the CO–OPs. This was the problem with the Colorado CO–OP failure, and we recently learned that the program lacked sufficient funds to reimburse for 2014 claims.

Now, Mr. Morrison, the risk-corridor program is only reimbursing the CO–OP claims at 12.6 percent of what they're owed; is that correct?

Mr. MORRISON. That's correct.

Ms. DEGETTE. And if Congress had not made this program budget neutral, would it be fair to say that the payments from the risk-corridor program would have likely made a difference in keeping a lot of these CO–OPs solvent?

Mr. MORRISON. I have read news accounts from a half a dozen or so CO–OPs before the most recent closures, that specifically attributed their closures to the government reneging on the risk-corridor payments.

Ms. DEGETTE. Now, Dr. Beilenson and Mr. Morrison, what additional—let's start with you, Dr. Beilenson. What additional steps do you think that we can take to ensure the continued viability of the CO–OP?

Dr. BEILENSON. Well, I think as I was talking about before, revising the risk adjustment formula. And by the way, Medicare advantage's risk-adjustment formula was tweaked several times over a 10-year period.

Ms. DEGETTE. Right.

Dr. BEILENSON. Secondly, pay the risk corridor that was required. And third and probably as important, is allow us to have the flexibility to go after private capital as any truly free market allows you to do.

Ms. DEGETTE. Mr. Morrison?

Mr. MORRISON. I made recommendations in my written statement, but the ones that Peter has suggested are important. I just want to say about the risk corridor, that when you send these little boats into a hurricane to learn how to sail, it's critically important that there be a Federal backstop, because they don't have any other business to balance things against. And that's why the risk-corridor payments are very important.

The other thing I want to say is that the risk-corridor payments and full payment of it was promised repeatedly to the CO–OPs. And so the CO–OPs and their actuaries took that into account from the very beginning with rating.

Ms. DEGETTE. Now, you said we needed a Federal backstop for these. What's the public interest in having that Federal backstop for these small boats?

Mr. MORRISON. Because it takes a few years. We didn't know until 2016 what this risk pool looked like. That's why you had big rate increases this year. And so the Federal backstop allows room for aggressive competition. The CO–OPs come in and add to that competition. Now everybody lost money. $2.5 billion, Wall Street Journal said 2 days ago from the McKinsey report on how much all the insurers had lost in those——

Ms. DEGETTE. But the CO–OPs didn't have any way to recoup that. I'm out of time.

Mr. MORRISON. The CO–OPs were not outliers in pricing. The CO–OPs were pricing competitively. Everybody lost money, but the CO–OP needed the Federal back stop, because they did not have the corporate depth to do it.

Ms. DEGETTE. Right. To do it. Thank you very much.

Mr. MURPHY. Thank you.

Mrs. Blackburn is recognized for 5 minutes.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

Thank you, all, for being here.

Mr. Morrison, I think it's important to note that any business in the country can be you can successful if it had a Federal backstop and somebody that was going to be there, and people have grown quite weary of bailouts.

Ms. McPeak, I want to come to you and talk about the CMS enhanced oversight plans. Was the Tennessee CO–OP under an enhanced oversight plan?

Ms. MCPEAK. The first notification we had about the enhanced oversight plan for the Tennessee CO–OP was on September 29 when we received a letter that I think I've attached to my testimony. What's problematic about that day is that we were also in discussions with CMS to lift the enrollment freeze for 2016 without any knowledge that the enhanced oversight plan was going to be coming our way.

Mrs. BLACKBURN. So you were getting conflicting information from CMS. The enhanced oversight plan for the Tennessee CO–OP included what?

Ms. MCPEAK. There were five pages of issues in the letter that were identified that were areas that the CO–OP needed to focus on to create greater financial stability and create better viability for the plan going forward.

Mrs. BLACKBURN. So they were giving you conflicting information; on one hand you had this, and on one hand the other?

Ms. MCPEAK. We were under the impression that CMS felt much more comfortable with the financial stability of the CO–OP, and that's why we were requested to lift the enrollment freeze by October 1, so that the programming could be effectuated to be available for open enrollment starting November 1. So we were surprised by the notification of the enhanced oversight plan.

Mrs. BLACKBURN. OK. Now, let's talk about the solvency, because they converted the solvency loans, the startup loans and seven CO–OPs, so that the loans would artificially appear more financially secure. So did CMS approach you about converting those loans so that the CO–OP would appear to have more capital on its books?

Ms. MCPEAK. CMS had indicated that they were in agreement with that approach, and so the actual request came from our CO–OP itself, CHA——

Mrs. BLACKBURN. To recharacterize——

Ms. MCPEAK. Yes, ma'am.

Mrs. BLACKBURN [continuing]. To recharacterize those loans.

Did you think it made sense to convert those loans?

Ms. MCPEAK. In my analysis, we decided that was not a prudent course of action, because, in fact, you are not adding any capital or revenue to the benefit of the company. You're creating the impression on the balance sheet that the debt could be subordinated and the company would appear more financially healthy than we felt that it was.

Mrs. BLACKBURN. So it's kind of a smoke screen type practice?

Ms. MCPEAK. Well, it certainly doesn't add any additional dollars to pay claims for the company.

Mrs. BLACKBURN. Right. Let's see, is it true that you were instrumental in relegating the Tennessee CO–OP so that the premium prices were appropriate and that consumers were protected?

Ms. MCPEAK. Yes. It's difficult to look at premium increases that have been approved in Tennessee. We took that very, very seriously. But as has been mentioned here today, we need companies to be able to make good on the claims, and the losses were more problematic for all companies. And so, yes, we definitely took an interest in making sure that our premiums were appropriate for the CHA in 2016.

Mrs. BLACKBURN. Let me ask you this: Does the CO–OP have enough money to support consumers and pay its claims through the end of the year?

Ms. MCPEAK. Because we took the decisive action of going into runoff, we do believe that the claims will be paid for all services rendered through the end of the year.

Mrs. BLACKBURN. Through the end of the year.

OK. And let me go back to Dr. Murphy's questions. You were talking about the enrollment and it didn't hit a thousand. What was the projected enrollment from the CO–OP, and what did CMS project that enrollment to be for 2016?

Ms. MCPEAK. I would have to research the number, but I do believe that it was probably close to the 12- to 15,000 enrollee range for the first year growing to something more along the 20,000 enrollee range for 2015.

Mrs. BLACKBURN. So their projection was 12- to 15,000 people, and what they actually got was about a thousand?

Ms. MCPEAK. At its highest point.

Mrs. BLACKBURN. So they were that far off their mark?

Ms. MCPEAK. Yes, that's correct.

Mrs. BLACKBURN. OK. Thank you very much for that.

Mr. Chairman, I will yield back 30 seconds of my time.

Mr. MURPHY. There you go. Thank you.

I now recognize Mr. Pallone, if he's ready it, for 5 minutes.

Mr. PALLONE. Let me get my questions out here, Mr. Chairman, if I can find them.

Congress established CO–OPs to do a number of things that the private market had not done, and specifically, CO–OPs were created to compete with large for-profit insurance companies and hopefully, put downward pressure on premium prices and serve parts of the country that had fewer, no-good insurance options.

So I wanted to ask Mr. Morrison, remind us of what the landscaped looked like for the consumer prior to the arrival of CO–OPs, particularly in rural regions. Is it accurate to say that there was minimal competition and the policies were often prohibitively expensive?

Mr. MORRISON. All of those things are true, Ranking Member Pallone. In Montana the uninsured rate was about 20 percent. As I said, with the introduction of the CO–OP, the difference in average premiums between Montana and Wyoming went from Montana being 13 percent lower to being 40 percent lower. We now have an uninsured rate that's, I think, closer to 11 or 12 percent in our state. Many, many thousands of people are now covered, who didn't use to have insurance. Many, many thousands of people are now able to afford insurance, who were not able to afford insurance before. And with the CO–OP, consumers now have more choices.

Mr. PALLONE. All right. Let me read a passage from a January 2015 study by the Commonwealth Fund, regarding what the landscape looked like prior to the passage of the Affordable Care Act. And it says, and I quote, "Most States' markets for individual health insurance were dominated by one or two carriers that competed primarily on how well they will they were table to screen and select people based on the risk of incurring medical claims. They had little incentive to compete by providing efficient services. In-

stead, their focus was on reducing their risk of covering people who might have a very high medical cost."

So, Mr. Morrison, that sounds look a rather bleak insurance landscape. Did insurance companies compete largely by denying coverage?

Mr. MORRISON. There's no question that segmenting the market and cherry picking to provide health insurance to the healthy people and exclude or price up the people with health issues was what was going on before the ACA, and that was certainly happening in Montana. In my experience, as the chair of the health insurance committee of NAIC, I saw it across rural America.

Mr. PALLONE. And, Mr. Beilenson, would you agree with that, what he just said?

Dr. BEILENSON. I believe so, but it's not my area of expertise.

Mr. PALLONE. OK. Let me go back to Mr. Morrison. Is it also accurate to say that prior to the passage of the ACA and the establishment of CO–OPs, many rural areas were underserved? And what did that mean for Montana residents?

Mr. MORRISON. What it meant for Montana residents was that if they were unable to get health insurance, in many cases, they were unable to get the health care that they needed. And access to health care has improved because access to health insurance has improved.

The other thing that's happened is although BlueCross BlueShield, which is now owned by Health Care Service Corporation, one of the BlueCross corporate groups, still is the dominant carrier in the State of Montana. Their market share is somewhat smaller now, and consumers have the choice of the CO–OP, and so there's more competition.

Mr. PALLONE. Well, before the ACA, were there many rural residents being rejected for insurance or only being offered excessively costly policies?

Mr. MORRISON. We found, when I was insurance commissioner, that most of the uninsured were people who worked full time for a small business. And the greatest area of difficulty in delivering health coverage to people was through small businesses that wanted very much to provide health coverage to their employees, but they couldn't afford what the coverage cost in the market. That's why we undertook a program called Insure Montana, before the ACA, before the Massachusetts plan, that provided refundable tax credits to help those small businesses afford health insurance.

Mr. PALLONE. All right. Just one more question. Based on your experience, how have CO–OPs served the rural West and States such as Montana? Has it provided important competition and access to health care that previously didn't exist?

Mr. MORRISON. Well, CO–OPs have a great tradition in rural America. I think Senator Conrad, when he introduced the idea of a CO–OP at the time of the ACA's enactment, talked about those. But people in our part of the country and across the great expanse between the coasts in the United States have long used the CO–OP model for credit, for electricity, for agriculture, and for other kinds of needs where they want to spread risk and spread expense to be able to deliver the goods and services that they need.

Mr. PALLONE. All right. Well, I'm obviously concerned that if we don't shore up the remaining CO–OPs, we may again find ourselves lacking adequate competition and choices in rural areas. But thank you.

And thank you, Mr. Chairman.

Mr. MURPHY. Thank you.

Dr. Bucshon, you are recognized for 5 minutes.

Mr. BUCSHON. Thank you, Mr. Chairman.

I just would like to say at the outset, I'm a strong believer in competition is the way to drive down healthcare costs. And I was a provider before I was a heart surgeon, so I'm also a believer in provider competition, including price transparency, quality transparency, and other measures that help consumers know what product they are getting and help to drive down healthcare costs, and I'm working towards those ideas.

And I think it's unfortunate that we are in the situation we are now with the CO–OPs and we need to figure out why and what we can do to prevent the others from going under.

Mr. Morrison, CMS is—well let me see—yes. I'll say this. CMS has cited enhanced oversight plans is a measure to evaluate troubled CO–OPs. These plans are being critiqued as ineffective and burdensome to CO–OPs. This would be for Mr. Beilenson first. Has your CO–OP been placed under an enhanced oversight plan from CMS?

Dr. BEILENSON. Yes, as far as we know, most of the CO–OPs have been put——

Mr. BUCSHON. Most of them have.

And what kind of requirements have they put upon you based on that?

Dr. BEILENSON. There are only two. One is enrollment getting to 30,000. We are at 26,500 today. Clearly, we'll hit that by the end of December. December is a big month. And, second, there's a resolve transition of our TPA, which we've already done. So we expect to come off of the corrective action plan.

Mr. BUCSHON. Great. And do you believe that these oversight plans can be effective?

Dr. BEILENSON. I think the oversight plans can be effective, yes.

Mr. BUCSHON. Mr. Morrison, you have some comments on any of this?

Mr. MORRISON. I would just say that it has certainly been a challenge for CO–OPs to face, not only state regulation, but several levels of CMS regulation and congressional oversight investigation, which began before the CO–OPs ever opened their doors. And so there's no question that administrative resources in these CO–OPs have been distracted and diverted to comply with multiple levels of regulation that far exceed the regulation of other carriers.

And at the same time, I understand that the Federal Government needs to look after its money.

Mr. BUCSHON. Understood.

And just a personal kind of question, unrelated, really, to CO–OPs. I mean, creating more competition, and anyone can answer this. Is expanding the traditional healthcare private insurance market across the country rather than having, essentially, state-based or regionally based, is that a concept that would work to cre-

ate more competition? I think the state regulators would probably want to commend on that. Mr. Donelon?

Mr. DONELON. May I? Thank you very much, Congressman. And great question, doctor.

And I would caution my Republican colleagues, who have made a strong push toward authorizing companies to sell health insurance on a national basis, which they can do already, but subject to the individual State's regulation.

I would be concerned about a race to the bottom and the least regulation, similar to what happened with the AIG failure. And that concern is truly—I had a meeting with one of my delegation members before coming here this morning and passed on that advice and caution to him.

I do want to point out one other thing when Congresswoman Blackburn and Commissioner McPeak were discussing, Tennessee is better served than Louisiana at this point. Their HMOs are protected by a guarantee fund safety net, unlike Louisiana, where we have tried that in the past but unsuccessfully.

The Ranking Member DeGette, was talking about a Federal backstop. That has traditionally been done at the state level and should be done at the state level.

Mr. BUCSHON. OK.

Mr. DONELON. In closing I would say, please, support state-based regulation. It has served all forms of insurance extremely well for over 100 years. When I was NAIC president 3 years ago and was asked to come the Oval Office and meet with the President, he strongly expressed his continued support for regulation of insurance at the state level.

Mr. BUCSHON. OK. Fair enough. I expected that you and Ms. McPeak would probably have a similar comment. So I would go to the others.

Any other conceptual thoughts on that? Because the whole idea is to create competition for consumers to have more choice, to know what the product they're getting, and to help the consumers drive down the costs of health care.

Mr. Morrison, then we'll——

Mr. MORRISON. I'm a former commissioner, too, and I testified in 2005 in the Senate Small Business Committee about the AHP bill, and I opposed it for the same reasons that Commissioner Donelon articulated.

Mr. BUCSHON. Ms. McPeak.

Ms. MCPEAK. The only point that I would want to add to your question, that I think we would have more interest in companies selling across state lines if we had uniform essential health benefit plan designs. Because each state has their own essential health benefits, it's very difficult for a company to sell across state lines and program their systems to pay for different benefits and different benefit levels in Kentucky as opposed to Tennessee as opposed to Mississippi or Georgia.

Mr. BUCSHON. Yes, and whose state laws apply, right? If you live in California and have a plan from a company owned in New York, which state's laws would apply? I know there's some challenges. And my time is up.

Ms. MCPEAK. OK.

Mr. BUCSHON. So, I appreciate all your comments.

I yield back.

Mr. MURPHY. Thank you.

Ms. Castor, you are recognized for 5 minutes.

Ms. CASTOR. Thank you, all, very much for being here today.

Under the Affordable Care Act, Congress wanted to foster more competition among insurance providers to benefit consumers. This was one of the primary reasons behind the formation of the CO–OPs. And to some extent, as we've heard here this morning, they have achieved their goal, somewhat.

However, the CO–OPs have faced headwinds. And I would like to understand from our witnesses how CO–OPs can continue to meet the original goals of providing the public with more insurance choices and benefits achieved through greater competition?

Mr. Morrison, for those who may not closely follow healthcare economics, why are CO–OPs an important ingredient in today's insurance market?

Mr. MORRISON. The insurance markets were lacking competition to begin with, and now we see in the news that there is increasing mergers of the largest health insurance companies in the country. There's mergers of the largest hospitals in the country. What's happening is consolidation, and the need for competition has never been more greater than it is today.

CO–OPs can come into the marketplace and have a fundamentally different kind of motive. Their motive is not to make as much money as they can. Their motive is to deliver quality health care at an affordable price, and that guides corporate decisions in a different kind of way. And that kind of competitive influence can be very positive in the marketplace.

And in short, to answer your question, what they need in order to succeed in the future, eventually, they will stand on their own, but they need adequate capital until they can get their sea legs in this new marketplace.

Ms. CASTOR. OK. Mr. Beilenson, similar question for the lay person, how do CO–OPs foster competition? How can they keep premium prices in check?

Dr. BEILENSON. Well, I think as a new competitor on the market and additional competitor, we as, Mr. Donelon, state, have a big insurance company that's 75 percent of the marketplace, and so adding a new competitor is very important.

And I want to point out a couple of things about a CO–OP. First of all, we are member governed. I actually sort of pooh-poohed that when we started the company, but it really makes a difference having members enrolled in your insurance company as the board of directors. We've gotten all sorts of great ideas, and it's very consumer-driven, consumer friendly, as the CO–OP program was meant to be.

Secondly, it allows for innovation. We're nimble; we're quick. We're like a, sort of like—a Titanic I shouldn't use. Sort of like the giganto ship, Lake Erie or whatever. Instead, we're sort of a nimble PT boat, if you will, for Mr. Kennedy over there. And we can do innovative things like our diabetic program, where we get rid of all co-pays, co-insurance, deductibles for proven practices to keep dia-

betics under control so we get rid of financial barriers to have them staying healthy. That's sort of the sweet spot of healthcare reform.

Ms. CASTOR. How many Americans are enrolled in CO–OPs today? Do you know?

Dr. BEILENSON. Depends on how many are left. I'm not sure, 500——

Ms. CASTOR. Does anyone know?

Dr. BEILENSON. 400,000 something in the remaining 11.

Ms. CASTOR. In March 25th, 2015, press release from the National Alliance of State Health CO–OPs, said for the second year in a row, average premium rates in the states with CO–OPs are lower than those without.

Mr. Beilenson, can you explain how, in reality, what has actually happened? How have the CO–OPs affected the premium prices and plan choices in those states where they are still operating?

Dr. BEILENSON. Well, predominantly, it was actually being a new competitor in a generally staunchly over the market—for example, in Maryland, we were the first new commercial insurer in 25 years, and that was the case in many different states.

Ms. CASTOR. And that same release cites another analysis from 2014 that showed that CO–OP states have premiums that are 8 to 9 percent lower than in non CO–OP states. Is that accurate? Were CO–OPs able to drive down the premium rates in 2014?

Mr. MORRISON. The delta between the CO–OP states and the non CO–OP states in 2014 was, as you said, about 8 percent, a little more than that. And apparently, in 2015, it was more like 13 percent. We believe that CO–OPs played a significant role in that, and, frankly, there have been other insurance executives who have commented in the media that they thought that the CO–OPs were responsible for the rates being lower in those states. But as the question requires further study because, obviously, there are other factors at work.

Ms. CASTOR. And there are other trends right now, as Mr. Beilenson mentioned. The health insurance industry is facing a wave of consolidation such as Aetna and Anthem are considering merger and purchasing their smaller rivals.

Mr. Morrison, if additional consolidation between large insurance companies occurs, what will this do to prices? Will we expect higher premiums as a result?

Mr. MORRISON. Generally, competition drives lower prices. And so if there's less competition, there's higher prices. And so we think that's one of the reasons that the CO–OPs were created, and we take that mission pretty seriously—the CO–OPs I should say do.

Ms. CASTOR. Thank you. We have work to do on this for consumers in the country. Thank you very much.

Mr. MORRISON. Thank you.

Mr. DONELON. Mr. Chairman, may I be excused? I have a flight that leaves in 38 minutes.

Mr. MURPHY. Good luck getting to the airport. You are excused.

Mr. Collins is recognized for 5 minutes.

Mr. COLLINS. Thank you, Mr. Chairman. And thank the witnesses for coming in today. I'm a private-sector guy that understands how you're supposed to make money in business, how you capitalize companies, and how you either fail or succeed based on

your pricing and your product, and what you've delivered to your customers. And basically, if you make money, you succeed; and if you lose money, you don't.

So, we're here today talking about CO–OPs in particular. And I'm from New York, where the New York CO–OP and its failure cost the American taxpayers over $250 million. Well, somebody asked me if I'd be surprised we're here today. Well, no, I predicted this over 2 years ago. I remember sitting down with some insurance executives, health insurance people, in early 2013 and asked them how they were going to be pricing their products for ObamaCare and for the enhanced benefits. And what basically came out of those meetings is they were going to underprice their products because of the risk corridors, and they were confident they would get the money back.

Because I said, well, what are you presuming for the number of healthy subscribers under age 30? Well, a third of our subscribers will be young and healthy. And I said, what are you guys smoking? That's not gonna happen. And what's going to happen when it doesn't? Well, we are going to lose money, then the government is going to make it up to us. This was set up for failure from day one. The insurance companies knew it was going to fail. They released a product that was underpriced. They could not make money.

So, Mr. Morrison, when you talk about it being not capitalized properly, would you agree with me if the CO–OPs made money, we wouldn't be having this discussion? You don't need more capital if you start with X and you make money. Isn't that just fundamental common sense?

Mr. MORRISON. I would agree with that.

Mr. COLLINS. So——

Mr. MORRISON. All the companies lost money.

Mr. COLLINS. So we are here because ObamaCare was set up for failure. It was set up to encourage low premiums, to deceive the American public.

You know the saying, you can put lipstick on a pig, but it's still a pig. That's what we've got here. Everyone knew these products were underpriced and they were going to make it up on the backs of the taxpayers, and that's why we're here today. This problem here is a product that was underpriced, knowingly underpriced, meant you lost money, and now the complaint is we cut the money from $2.4—from $6 to $2.4 billion, but the $6 billion was based on 50 CO–OPs. The 23 got $2.4 billion. They got every dollar they were supposed to get. Had we not cut from $6 to $2.4, there would be 50 CO–OPs.

So I kind of have to just categorically disregard your comment that had we thrown $6 billion, but I think you're suggesting throwing $6 billion at 23 CO–OPs would have shored them up. But that was never the intention. The $6 billion was for 50 CO–OPs. The 23 were not harmed in any way. They failed because the product was underpriced. It was knowingly underpriced.

ObamaCare was meant to deceive the public, and all I can say is, as now we're a couple of years in, the deception is obvious. And I don't know what the polls would say, and I'm not a guy to poll, but I think ObamaCare now would be probably in the 20 percent range.

And now we've got these problems. New York, 150,000 members on the New York plan lose their insurance in 2 weeks. And you know what we're doing, we're forcing the private companies to take those policyholders for 30 days who have all hit their deductibles. So the BlueCross BlueShield, Independent Health, they are going to have to take these 150,000 people for 30 days, eat those losses, and then have those folks set up a new plan. This is ObamaCare at its worst. It's not surprising to me. I saw this coming 3 years ago, only because I have a certain level of common sense and know in the private sector, if you underprice your product, there will be a price to pay.

And this product was deliberately underpriced from day one. And then when people say, woe is me, the risk corridor didn't give me as much money as I expected, that's because you expected to lose a lot of money and thought the taxpayers should shore that up, and it didn't happen. So I can't say I feel sorry for the American taxpayers who are bearing this financial burden who were deceived from day one, and it's all coming home to roost. And we see it every day with the price increases and policies, the turmoil within the American public trying to find doctors day in and day out.

So, again, private sector, you make money, you do fine. You lose money, you don't do fine. Not a surprise we're not doing fine here. The product was never priced correctly.

Mr. MURPHY. Mr. Collins——

Mr. COLLINS. And with that, I yield back.

Mr. MURPHY. I was asking, can you give an answer with regard to would you have priced it differently if there were not risk corridors from the onset? Would you price it a higher? Yes or no? Just in response to what he said.

Dr. BEILENSON. No, we actually priced conservatively, and we were actually making a profit the last 3 months.

Mr. MURPHY. Ms. McPeak, was that a backstop that you saw that would cover those losses and it didn't work?

Ms. MCPEAK. I don't know that I would characterize as a backstop. But certainly, the incentive to appropriately price was eliminated when any excess profit of needed to be paid back to the other insurers. So unless the entire market priced appropriately, you were going to be pricing yourself out of the market not having the enrollment.

Mr. MURPHY. And that's what you're saying. Got it. Thank you.

OK. Mr. Yarmuth, 5 minutes.

Mr. YARMUTH. Thank you, very much, Mr. Chairman.

I thank the witnesses. I actually think this has been a very constructive hearing, and the dialogue has been good. It seems to me that what we've heard today is that there are a lot of different experiences with CO–OPs and a lot of different reasons some have had problems.

My CO–OP in Kentucky did not have an enrollment problem. As a matter of fact, the initial projection was about 30,000 enrollees. It peaked at 57,000 and was insuring 51,000 when it announced that because of the risk-corridor deductions it cannot sustain itself. But, in fact, it had gone from losing $50 million in its first year to losing $4 million in 2015 and was on track to make a profit in 2016. So not every experience has been right.

And I think looking at the various factors that could affect this, Commissioner McPeak, Tennessee didn't expand Medicaid.

Ms. MCPEAK. That's right.

Mr. YARMUTH. And this is not a partisan statement, but Tennessee did not have an administration that supported, necessarily, the Affordable Care Act. So as opposed to Kentucky's experience, where you had an administration that was very much supportive in marketing it and running a PR campaign and alerting the population to the options that were available to them, that experience was going to be different than Tennessee's or Louisiana's, where, it seems to me, you had an enrollment problem first and foremost.

Would that be a fair statement that all of these factors would affect how the CO–OPs operated and whether they had a better or worse chance of succeeding?

Ms. MCPEAK. Certainly. And I will say statewide, we had a very positive enrollment through the federally facilitated marketplace. So we did not expand Medicaid. But the skewed enrollment of less than 1,000 people for the CO–OP made it extremely difficult to survive.

Mr. YARMUTH. Exactly. And, obviously, we have different health conditions as well. Montana probably has a lot healthier population than Kentucky and Tennessee. I know Kentucky, we have serious challenges in that regard.

But one of the things that impresses me, and this relates to just Mr. Collins' statements, is that while our CO–OP is going out of business, we have three new private insurers who have joined our exchange. We now have seven insurers who are offering insurance and not relying on risk corridors. So they have seen opportunity in Kentucky and not a disastrous situation.

And so our consumers are going to, as a result partially of the CO–OPs competition and their activities, we're going to see enhanced competition in the private market through our exchange. So it could have an ancillary benefit as well. Would that not be true, Mr. Morrison?

Mr. MORRISON. That's very encouraging, and I think that the benefits of introducing a CO–OP into the dynamics of the marketplace has lots of ripple effects, and that was one that I wasn't even aware of. So glad to know about that.

Mr. YARMUTH. And one other thing. Senator just asked, we talked about the question of how can you offer insurance policies of 20 percent less than commercial insurance company can? Well, if there's no profit margin involved, so you can. I don't know whether it would be a 20 percent different as to the profit versus a nonprofit CO–OP, but there's some factor there that would allow a CO–OP to offer pricing that even apples to apples would be below what a commercial for-profit insurance company could offer. Would that be correct?

Mr. MORRISON. Yes, that's true. But I want to make the point that the CO–OPs generally were not outliers on the low end in price. And McKinsey did a report in late 2013 about those initial prices, and CO–OPs were toward the bottom. They were within 10 percent of the lowest 42 percent of the time. But the point is, when these companies set their prices and file them with the commissioner, they don't know what the other companies are doing. And

so the mere fact that the CO–OPs were there caused the other companies to price more aggressively.

Mr. YARMUTH. So what I'm taking away from this is that there are lot of different reasons the CO–OPs have either succeeded or not succeeded, and I think this is a very useful hearing to analyze that, not necessarily to ascribe blame, but to take about the factors that are involved. I think what I would conclude is there was not a fundamental flaw in the Affordable Care Act that caused any of those CO–OPs to fail. They were different factors, just as there is in any business situation.

With that, Mr. Chairman, I yield back.

And thanks again to the witnesses.

Mr. COLLINS [presiding]. I thank the gentleman for questions and certainly thank all the witnesses. This will conclude our second panel, and you can rush to the airport if you've got any tight flights. I want to thank the members that did stay. It is a flyout day. We had so many members that had flights to connect. We had two vote series, so to some extent, I apologize for the attendance.

Thank the members that did stay, and your testimony, which is on the record, is very helpful. Thank you very much

So we are now going to bring on our third panel, which is our representative from CMS and our representative from OIG.

We will begin our third panel here. I want to thank the witnesses, Dr. Cohen and Ms. Jarmon, for joining us today. Before we get going on this committee, we want to make sure the witnesses are aware that we are holding an investigating hearing, and when doing so, we have the practice of taking testimony under oath. Do you have any objection to testifying under oath?

The chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony today?

No. In that case, if you would, please rise, raise your right hand. I will swear you in.

[Witnesses sworn.]

Mr. COLLINS. Thank you very much. Be seated. You are now under oath and subject to the penalties set forth in title 18, section 1001, of the United States Code.

We now recognize you to give a 5-minute summary of your written testimony beginning with Dr. Cohen, chief of staff for CMS.

Dr. Cohen?

STATEMENTS OF MANDY COHEN, CHIEF OF STAFF, CENTERS FOR MEDICARE AND MEDICAID SERVICES; AND GLORIA L. JARMON, DEPUTY INSPECTOR GENERAL FOR AUDIT SERVICES, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF MANDY COHEN

Dr. COHEN. Thank you. Good afternoon, and thank you for inviting me here. Chairman Murphy, who I know has gone, but Mr. Collins, Ranking Member DeGette, and other members of the subcommittee. We appreciate the opportunity to talk about the CO–OP program. CMS takes its commitment to both the CO–OP con-

sumers and taxpayers very seriously. Our priority is to make sure that consumers have access to quality affordable coverage.

In the years since the passage of the Affordable Care Act, we have seen an increase in competition and more choices for consumers. In today's dynamic market, consumers can choose from on average 50 plans and five issuers for 2016 coverage. Nearly 9 out of 10 returning consumers will have three or more issuers to choose from, which research shows has typically intensified price competition in the market. New entrance to any market, especially the insurance market, can face pressures particularly in early stages.

CO–OPs entered the insurance market with a number of challenges including building a prior network; no previous claims experience on which to base pricing; and competition from larger, more experienced issuers; as well as the uncertainty that a company is in the early years of a new market. As with any new business venture, some CO–OPs have succeeded while others have encountered more challenges. There have been successful CO–OPs which have provided consumers in their states an additional choice of health insurance and have improved competition. There have also been CO–OPs that for a number of reasons have faced technical, operational, or financial difficulties. In addition, Congress has made a substantial rescission to the initial $6 billion for funding for CO–OPs, impacting program operations and available funding. In the face of multiple pressures, it is not surprising that some new entrants have struggled to succeed.

CMS plays a dual role with the CO–OP program, providing both oversight and support. CMS works to give CO–OPs tools to succeed, including sharing best practices amongst CO–OPs, and looking for additional regulatory flexibilities. At the request of CO–OPs, CMS has approved conversion of surplus notes, and we have approved the infusion of outside capital consistent with legal and regulatory framework of the CO–OP program. CMS also plays an oversight role. CMS, along with state departments of insurance, which serve as the primary regulator of insurance in a state, work to ensure that the CO–OPs are well run and financially sound. CMS has implemented the CO–OP program as required by statute and with the funds available, evaluating applications, monitoring financial performance, and conducting oversight. All CO–OPs are subject to standardized, ongoing oversight activities, including calls to monitor goals and challenges, periodic onsite visits, performance and financial auditing, reporting obligations, and a host of additional measures employed as needed on a case-specific basis, such as the evaluation of CO–OP sustainability. CMS increased the data and financial reporting requirements for CO–OPs required for them to provide quarterly statements saying that they are in compliance with state licensure requirements. If a CO–OP has experienced compliance issues with state regulators, the CO–OP was required to describe the steps being taken to resolve those.

Financial data collection has helped CMS to identify CO–OPs with financial issues and give CMS the opportunity to work with state insurance regulators to help correct issues that are identified. As part of our oversight efforts, CMS has put some CO–OPs on enhanced oversight schedules or corrective action plans. Despite this

support and oversight, some new entrants to the insurance market have struggled to succeed.

When states and CMS determine that a CO–OP should wind down, our first responsibility is to make sure current policyholders are able to retain coverage to the end of the year. CMS' priority is to make sure that customers have access to quality, affordable coverage. We're working with local officials to do everything possible to make sure consumers stay covered and retain access to high quality choices of issuers. Like other consumers, CO–OP enrollees are able to shop for 2016 coverage on the marketplace right now.

In 2016, nearly 8 in 10 returning marketplace consumers will be able to buy a plan with premiums less than $100 a month after tax credits. We continue to encourage those consumers already enrolled in the marketplace coverage to come back to the marketplace, update their information, compare their options, and make sure they're enrolled in the plan that best meets their family's needs. Since the enactment of the Affordable Care Act, CMS has worked to increase access to quality, affordable coverage through the marketplace while being responsible stewards of taxpayer dollars. The CO–OP program was designed to give consumers more choice, promote competition, and improve quality in the insurance market and has done so in a number of states. CMS will closely work with the CO–OPs and state departments of insurance to provide the best outcomes for consumers. We appreciate the subcommittee's interest and be happy to answer more questions.

[The prepared statement of Ms. Cohen follows:]

STATEMENT OF

MANDY COHEN, M.D., MPH

CHIEF OPERATING OFFICER AND CHIEF OF STAFF

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

THE CONSUMER OPERATED AND ORIENTED PLAN (CO-OP) PROGRAM

BEFORE THE

UNITED STATES HOUSE COMMITTEE ON ENERGY & COMMERCE

SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

NOVEMBER 5, 2015

The Consumer Operated and Oriented Plan (CO-OP) Program
U.S. House Committee on Energy & Commerce,
Subcommittee on Oversight & Investigations
November 5, 2015

Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee, thank you for the invitation to discuss the Consumer Operated and Oriented Plan (CO-OP) Program. The Centers for Medicare & Medicaid Services (CMS) takes its commitment to both the CO-OP consumers and the American taxpayers seriously and we are working hard to help all Americans access high quality, affordable health insurance coverage.

CMS' priority is to make sure that Marketplace customers have access to quality, affordable coverage through the Marketplaces. In the years since the passage of the Affordable Care Act, we have seen increased competition and more choices for consumers; in 2016, nine out of ten returning customers will be able to choose from three or more issuers.[1] The CO-OPs have played an important role in that process, particularly in the early years of the Affordable Care Act. As we begin the third Marketplace Open Enrollment, CMS is eager to build on the success we have achieved in reducing the number of uninsured Americans - as several of the Affordable Care Act's coverage provisions have taken effect, an estimated 17.6 million Americans gained coverage.[2] We expect 10 million individuals to be enrolled in coverage through the Health Insurance Marketplaces and paying their premiums – so-called effectuated coverage – at the close of 2016.[3]

Section 1322 of the Affordable Care Act established the CO-OP program to foster the creation of non-profit health insurance issuers to give more choices and control to consumers, promote competition, and improve quality in the health insurance market. To this end, the law provided funding to eligible entities to help establish and maintain these new plans. Any start-up faces the inherent risks of building a business from the ground up. The funding provided by the law was intended to provide needed support while these non-profit insurance companies enter this

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[1] http://aspe.hhs.gov/sites/default/files/pdf/135461/2016%20Marketplace%20Premium%20Landscape%20Issue%20Brief%2010-30-15%20FINAL.pdf
[2] http://aspe.hhs.gov/health-insurance-coverage-and-affordable-care-act-aspe-issue-brief-september-2015
[3] http://www.hhs.gov/about/news/2015/10/15/10-million-people-expected-have-marketplace-coverage-end-2016.html

difficult market for new businesses. In implementing the CO-OP program as required by statute and with the funds available, CMS has been engaged in evaluating applications, monitoring financial performance, conducting oversight, and supporting state departments of insurance, which serve as the primary regulator of insurance issuers in the states.

CMS Implementation and Oversight of the CO-OP Program

The framework for implementing the CO-OP Program was based on the recommendations submitted by a Federal Advisory Committee appointed by the Government Accountability Office (GAO) under section 1322 of the Affordable Care Act to advise the Secretary of Health and Human Services (HHS) regarding the award of CO-OP loans. The Committee issued a final report in April 2011, and the major elements of how CO-OPs were selected, awarded loans, and monitored were based on the GAO-appointed Advisory Committee's report.

The CO-OP application-review process was rigorous, objective, and independent. An extensive two-tiered review process was established to review the loan applications, and Deloitte Consulting, LLP, was retained to administer the external review. In addition to verifying eligibility, Deloitte used a team of insurance experts, actuaries, business plan and financial experts, market analysts, delivery system experts, and former state insurance regulators to evaluate each element of the application. These elements included, but were not limited to, the business plan, enrollment strategy, management qualifications and health plan experience, and feasibility study in each application. The Deloitte recommendations were then sent to the internal CMS review committee, which was led by insurance experts and an actuary who was not on the CO-OP program staff. A July 2013 HHS Office of Inspector General (OIG) Report found that "CMS's oversight strategy includes frequent monitoring and early intervention to ensure that CO-OPs adhere to program requirements and goals."[4]

Twenty-four of 147 CO-OP applicants were selected to receive loan funds and ultimately entered into CO-OP loan agreements with CMS. CMS provided loan funding to the 24 CO-OPs in two forms, consistent with statute:[5] start-up loans and solvency loans. The total amount of start-up

[4] http://oig.hhs.gov/oei/reports/oei-01-12-00290.pdf
[5] Sec. 1322(b) the Affordable Care Act

loan funding obligated and available to a particular CO-OP was based on the estimated cost of specific start-up activities. Start-up loan funds were disbursed upon completion of start-up activities listed in a disbursement schedule that was incorporated into each CO-OP borrower's loan agreement.

As set forth in the statute, solvency loan funds assist loan recipients with meeting regulatory capital and surplus requirements of the state(s) in which they are licensed. CO-OPs requested additional loan funding to reflect new solvency loan needs to help CO-OPs continue to meet their state-determined solvency requirements. Each request should have included the CO-OP's estimated capital needs through the point at which the CO-OP would reach break-even and have operational cash flow or outside capital funding sufficient to allow the scheduled repayment of all CMS loans. Solvency loan award levels were set based on industry standards and state regulatory capital requirements.

In making additional award decisions, CMS reviewed applications for these subsequent loans, which included assessing new and updated business plans, conducting feasibility studies, and assessing programmatic and regulatory compliance, actuarial soundness, and pro forma financial statements. The applications included actuarially-certified analysis and financial projections, which necessarily incorporated data regarding the current and projected level of enrollment. An external panel reviewed and provided to CMS an assessment of each request for additional loan funding, consistent with processes used to make initial loan decisions set out in the CO-OP Program Funding Opportunity Announcement[6] and the CO-OP Program Final Rule.[7]

While the Affordable Care Act appropriated $6 billion for the program, the Congress made a number of substantial rescissions to that initial funding level. The Department of Defense and Full Year Continuing Appropriations Act, 2011, rescinded $2.2 billion; the Consolidated Appropriations Act, 2012, rescinded an additional $400 million; and the American Taxpayer Relief Act of 2012 further reduced the remaining $3.4 billion of CO-OP funding by rescinding 90 percent of funds unobligated as of the date of enactment. Finally, an additional $13 million

[6] https://www.cms.gov/CCIIO/Resources/Funding-Opportunities/Downloads/final_premium_review_grant_solicitation_with_disclosure_statement.pdf
[7] http://www.gpo.gov/fdsys/pkg/FR-2011-12-13/pdf/2011-31864.pdf

was reduced due to sequester in Fiscal Year 2013. The remaining balance was assigned to a new contingency fund available for oversight and assistance to the existing CO-OP loan recipients.

New entrants to any market, especially the insurance market, can face pressures, particularly in early stages. CO-OPs entered the health insurance market with a number of challenges, including building a provider network and customer support, no previous claims experience on which to base pricing, and competition from larger, experienced issuers. As with any new set of business ventures, some CO-OPs have succeeded while others have encountered more challenges. There have been successful CO-OPs, which have provided consumers in their states an additional choice of health insurance and have improved competition, and there also have been CO-OPs that for a number of reasons have faced compliance, technical, operational, or financial difficulties. In the face of multiple pressures, some new entrants have struggled to succeed and some will not sell coverage on the Marketplace in 2016. In these instances, CMS is working with state DOIs, the primary regulator of insurance issuers in the states to ensure consumers have adequate coverage and when necessary a smooth transition to another plan through open enrollment.

CMS takes its oversight of taxpayer funds seriously. Since awarding both start-up and solvency loans, CMS has closely monitored and evaluated all CO-OPs to assess performance and compliance. All CO-OPs are subject to standardized, ongoing program oversight activities that include weekly, biweekly, or monthly calls to monitor goals and challenges; periodic on-site visits; performance and financial auditing; monthly, quarterly, semi-annual, and annual reporting obligations; and a host of additional measures employed as needed on a case-specific basis, such as the evaluation of CO-OP sustainability. CMS also engages regularly with state DOIs, which serve as the primary regulator of insurance issuers in the states.

CMS appreciates the work and recommendations made by the HHS OIG, which have informed and improved our oversight of the CO-OP program. CMS increased the data and financial reporting requirements for CO-OPs, requiring them to provide a quarterly statement that they are in compliance with all relevant State licensure requirements or an explanation of any deficiencies, warnings, additional oversight, or any other adverse action or determination by State insurance regulators received by the CO-OP since the last-filed quarterly report. If the CO-

OP is experiencing compliance issues with State regulators, the CO-OP is required to describe the steps being taken to resolve those issues. In addition, CO-OPs have monthly and quarterly reporting requirements, including financial statements (audited financial statements when available), balance sheets, income statements, and statements of cash flow as well a statement of enrollment statistics. This additional financial data collection has helped CMS to identify underperforming CO-OPs and gives CMS the opportunity to work with State insurance regulators to help correct issues that are identified. Additionally, as recommended by the OIG[8], CMS has placed some CO-OPs on enhanced oversight schedules or corrective action plans. CMS also conducts on-site forensic audits to confirm the financial conditions of the CO-OPs. These efforts, among others, have helped us identify problems early.

CMS conducts site visits to ensure that CO-OPs are meeting their obligations to the program. Since March 2015, CMS has conducted site visits of plans in 14 states. We believe these visits are a benefit to plans, consumers, and taxpayers. These visits provide CMS an opportunity to see firsthand whether and how a CO-OP meets its obligations and how they can better serve their customers and taxpayers. As such, CMS reviews management structure and staffing, financial status, business strategy, the policies and procedures of the CO-OP, a CO-OP's marketing and sales, and the CO-OP's operations, including vendor management and oversight. CMS also reviews how a CO-OP is meeting their obligations in terms of medical management and member relations. CMS also works with DOIs to leverage each other's on-site CO-OP examinations.

For CO-OPs that will not sell coverage on the Marketplaces in 2016, CMS is working collaboratively with DOIs and the CO-OPs to wind down their operations in an orderly way, while minimizing disruptions to consumers. CMS is assisting where appropriate in the development and management of wind-down plans. Like other consumers, affected CO-OP enrollees are able to shop for 2016 coverage on the Marketplace throughout open enrollment, which started Sunday.

[8] http://oig.hhs.gov/oas/reports/region5/51400055.asp

Promoting Coverage in Open Enrollment 2016

The CO-OP program is only one part of the Affordable Care Act's overall approach to encourage competition and to give consumers a variety of affordable coverage choices. Whether consumers are getting coverage from a CO-OP, another issuer, or Medicaid, millions of Americans who were previously uninsured now have access to affordable, high quality health care coverage. As several of the Affordable Care Act's coverage provisions took effect, an estimated 17.6 million Americans gained coverage. Over that period, the uninsured rate dropped from 20.3 percent to 12.6 percent – a 38-percent reduction (or 7.7 percentage points) in the uninsured rate.[9] This success benefits Americans no matter where they get their health insurance. For example, reductions in the uninsured rate generally mean that doctors and hospitals provide less uncompensated care, the costs of which are often passed along to consumers and employers who pay premiums for health coverage.[10]

With the third Open Enrollment underway, we are eager to build on this success by not only retaining current consumers, but by increasing Marketplace enrollment. We expect to have 10 million individuals enrolled in coverage through Marketplaces and paying their premiums – so-called effectuated coverage – at the close of 2016. As part of that goal, HHS believes more than one out of every four uninsured Marketplace-eligible consumers will select plans during Open Enrollment. Consumers in the Marketplace will have a range of plans to choose from. Nine out of ten returning consumers will be able to choose from three or more issuers for 2016 coverage. And on average, consumers can choose from plans sold by five issuers for 2016 coverage, just as they could for 2015 coverage. Previous research shows that price competition typically intensifies with three or more competitors in a market. In 2016, consumers can chose from an average of 50 plans in their county.[11]

Prior to the Affordable Care Act, we lived in a world where double-digit premium increases were the norm, and those plan increases often paid for inferior policies. In 2016, nearly eight in ten returning Marketplace consumers will be able to buy a plan with premiums less than $100 month

[9] http://aspe.hhs.gov/health-insurance-coverage-and-affordable-care-act-aspe-issue-brief-september-2015
[10] http://aspe.hhs.gov/sites/default/files/pdf/83961/ib_UncompensatedCare.pdf
[11] http://aspe.hhs.gov/sites/default/files/pdf/135461/2016%20Marketplace%20Premium%20Landscape%20Issue%20Brief%2010-30-15%20FINAL.pdf

after tax credits. In addition, about seven in ten returning Marketplace consumers will be able to buy a plan for $75 or less in monthly premiums after tax credits in 2016. We continue to encourage those consumers already enrolled in Marketplace coverage to come back to the Marketplaces, update their information, and compare their options to make sure they are enrolled in the plan that best meets their budget and health needs. Last year, almost 53 percent of consumers who re-enrolled in a Marketplace plan shopped around with more than half of those selecting a new plan.[12] The average consumer who switched plans saved money on his or her net premium, based on an HHS analysis of Open Enrollment in 2015.[13] Net premiums are premiums minus the amount of applicable tax credit – the amount that is paid by a consumer. Those who switched plans within the same metal tier saved an average of nearly $400 on their 2015 annualized premiums after tax credits as compared to those who stayed in their same plans.

Improved Consumer Experience

Over the last few months, our team has been hard at work, taking steps to make enrollment quicker and smoother for both returning and new customers. Ahead of Open Enrollment 2016, new features were added to HealthCare.gov based on consumer feedback about previous experiences with the site and the type of additional information they want in order to pick the right plan. We made it easier for consumers to reset their passwords and have simplified re-enrollment so when consumers come back to HealthCare.gov, they will be able to easily find their current plan and compare it with other plans available in their area.

We are also providing more consumer-specific information, tailored to whether a consumer is new or is returning so that consumers will have an experience that matches their unique situation. A new Out-of-Pocket Cost feature has been added to the website this year that will help consumers better estimate the cost of health insurance based on their own personal situation, helping them understand overall costs, in addition to premiums.

[12] http://aspe.hhs.gov/sites/default/files/pdf/83656/ib_2015mar_enrollment.pdf
[13] http://aspe.hhs.gov/sites/default/files/pdf/134556/Consumer_decisions_10282015.pdf

Conclusion

Since the enactment of the Affordable Care Act, CMS has worked to increase access to quality, affordable coverage through the Marketplaces while being responsible stewards of taxpayer dollars. The CO-OP program was designed to give consumers more choices, promote competition, and improve quality in the health insurance market. Though not all CO-OPs have proven to be successful, thanks to the Affordable Care Act, consumers have a variety of affordable health insurance coverage choices that meet the health care needs of their families. CMS will continue to work closely with CO-OPs and state departments of insurance to provide the best outcome for consumers. We appreciate the Subcommittee's interest and I am happy to answer your questions.

Mr. COLLINS. Thank you, Dr. Cohen.
Now we'll hear from Ms. Jarmon.

STATEMENT OF GLORIA L. JARMON

Ms. JARMON. Good afternoon, Mr. Collins, Ranking Member DeGette, and other distinguished members of the committee. I am Gloria Jarmon, Deputy Inspector General for Audit Services, Department of Health and Human Services, Office of Inspector General. Thank you for the opportunity to testify today about OIG's work as it relates to CMS' oversight of financial loans and the financial solvency of the Consumer Operatedand Oriented Plans.

As part of our strategic plan to oversee implementation of ACA programs, OIG has performed three reviews related to CO–OPs. My testimony today focuses on OIG's most recent report issued in July 2015 that reviewed whether enrollment and profitability met the CO–OPs projections on their initial loan applications. Understanding that CO–OPs face numerous challenges, we conducted this audit work to assess the financial and operational status of the CO–OPs once they had experience operating as a health insurer. We reviewed the status of the 23 CO–OPs as of December 31, 2014. We found that most CO–OPs had lower than expected enrollment numbers and significant net losses and that these financial concerns might limit some CO–OPs' ability to repay loans.

Based on these findings, OIG issued four recommendations to CMS to improve financial oversight and solvency of the CO–OPs. These recommendations include: One, continue to place underperforming CO–OPs on enhanced oversight or corrective action plans; two, providing guidance or establishing criteria to determine when a CO–OP is no longer viable or sustainable; three, working closely with state insurance regulators to identify and correct underperforming CO–OPs; and, four, pursuing available remedies for recovery of funds from terminated CO–OPs. I will briefly discuss each of these recommendations in more detail.

With respect to enhanced oversight, with the 2011 funding opportunity announcement and loan agreements, CMS has the ability to place underperforming CO–OPs on enhanced oversight plans. This vehicle provides authority to CMS to conduct thorough reviews of the CO–OPs' operations and financial status.

With respect to guidance, to ensure that CMS can appropriately identify CO–OPs that pose a high risk of failure, CMS should establish criteria to assess whether a CO–OP is viable or sustainable. With respect to state insurance regulators, CMS should enhance its oversight by working closely with State insurance regulators who are the primary regulatory entities that oversee CO–OPs as health insurance issuers. By doing this, CMS can obtain timely insights as to the CO–OP's performance and can work with CO–OPs to address and fix ongoing financial and operational problems earlier.

Finally, if CMS no longer believes that a CO–OP is viable and sustainable, CMS should then pursue all available remedies for recovery of funds from CO–OPs. This would include the option to terminate loan agreements which would require the CO–OP to forfeit all unused loan funds. This may allow CMS to recover some portion of the loan with the recognition that a CO–OP must resolve any

outstanding debts or other claim obligations before paying the loan funds to CMS.

In closing, we appreciate the subcommittee's interest in this important issue and continue to urge CMS to fully address OIG's recommendations related to improving oversight and financial solvency within the CO–OP program. OIG is committed to providing continued oversight of this program. Our ongoing work will assess whether CO–OPs were in compliance with Federal regulations and program requirements in managing Federal funds. In addition, OIG will reassess the CO–OPs 2015 financial status and identify CMS actions to oversee the loan program and monitoring underperforming CO–OPs. We anticipate issuing these reports in 2016, and we look forward to sharing those results with the committee at that time.

This concludes my testimony. I will be happy to answer any questions. Thank you.

[The prepared statement of Ms. Jarmon follows:]

Testimony Before the United States House of Representatives
Committee on Energy and Commerce:
Subcommittee on Oversight and Investigations

"Examining the Costly Failures of ObamaCare's CO-OP Insurance Loans."

Testimony of:

Gloria L. Jarmon
Deputy Inspector General
Office of Audit Services
Office of Inspector General
Department of Health and Human Services

November 5, 2015
10:15 a.m.
Rayburn House Office Building, Room 2322

Testimony of:
Gloria L. Jarmon
Deputy Inspector General for Audit Services
Office of Inspector General, U.S. Department of Health and Human Services

Good morning Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee. I am Gloria Jarmon, Deputy Inspector General for Audit Services for the Office of Inspector General (OIG), U.S. Department of Health and Human Services (HHS). I appreciate the opportunity to appear before you today to discuss OIG's work as it relates to the Centers for Medicare & Medicaid Services' (CMS) oversight of financial loans and the financial solvency of the Consumer Operated and Oriented Plans (CO-OP).

The Patient Protection and Affordable Care Act (ACA) established health insurance exchanges (commonly referred to as "marketplaces") to allow individuals and small businesses to shop for health insurance in all 50 States and the District of Columbia. The ACA established the CO-OP program to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets. The ACA authorized the Secretary of HHS to provide loans to help establish new consumer-governed, nonprofit health insurance issuers, referred to as CO-OPs.

As part of our strategic plan to oversee implementation of ACA programs, OIG has performed three reviews related to CO-OPs. My testimony today will focus on OIG's most recent report issued in July 2015, which found that most CO-OPs had lower-than-expected enrollment numbers and significant net losses and that these financial concerns might limit some CO-OPs' ability to repay loans. We made recommendations to CMS to improve the agency's oversight of the loans and of the financial solvency of the CO-OPs.[1]

This most recent report builds on findings and recommendations that OIG made in two prior reports issued in July 2013.[2] Those reports examined CMS's selection process for CO-OPs and the early implementation of CO-OPs. Based on that work, we concluded that CMS awarded CO-OP loans in accordance with applicable Federal requirements, but we also identified several risks that indicated a critical need for additional CMS oversight of the CO-OPs as they prepared to become operational. For instance, we identified a risk that CO-OPs could exhaust all startup loan funding before they became fully operational or before they earned sufficient operating income to be self-supporting.

Understanding that CO-OPs faced numerous challenges even before they opened their doors for business, we conducted this most recent audit work to assess the financial and operational status of the CO-OPs once they had experience operating as a health insurer. We reviewed the status of the 23 CO-OPs as of December 31, 2014. The objective of this

[1] *Actual Enrollment and Profitability Was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loans Provided Under the Affordable Care Act*.
[2] *Early Implementation of the Consumer Operated and Oriented Plan Loan Program* and *The Centers for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Program Loans in Accordance with Federal Requirements, and Continued Oversight is Needed*.

review was to determine whether enrollment and profitability met the CO-OPs' projections on their initial loan applications.

OIG found that most of the 23 CO-OPs reviewed had not met their initial program enrollment and profitability projections as of December 31, 2014. Each CO-OP submitted a loan application that included details on its annual projected number of enrolled members and projected net income. Specifically, member enrollment for 13 of the 23 CO-OPs that provided health insurance in 2014 was considerably lower than the CO-OPs' initial annual projections, and 21 of the 23 CO-OPs had incurred net losses as of December 31, 2014.

By the end of our audit field work, 19 of the 23 CO-OPs had exceeded their 2014 calendar year projected losses as reported in the loan award application feasibility studies. CMS had placed four CO-OPs on enhanced oversight or corrective action plans (Kentucky, Louisiana, New Jersey, and Tennessee) and two CO-OPs under low-enrollment-warning notifications (Massachusetts and Oregon).

Based on these findings, OIG issued four recommendations to CMS in order to improve financial oversight and solvency of the CO-OPs. These recommendations include: (1) continuing to place underperforming CO-OPs on enhanced oversight or corrective action plans, (2) working closely with State insurance regulators to identify and correct underperforming CO-Ops, (3) providing guidance or establishing criteria to determine when a CO-OP is no longer viable or sustainable, and (4) pursuing available remedies for recovery of funds from terminated CO-OPs.[3]

Having examined the CO-OPs at different points throughout their implementation and operation, OIG believes that our four recommendations can help CMS provide further oversight and accountability for underperforming CO-OPs. In accordance with the CMS Funding Opportunity Announcement[4] dated December 9, 2011, and loan agreements, CMS should place underperforming CO-OPs on enhanced oversight plans. This would enable CMS to conduct thorough and more frequent reviews of a CO-OP's operations and financial status.

In addition, CMS can provide technical assistance if it were determined that doing so would improve the performance of the CO-OP and increase the likelihood of loan repayments.[5] Finally, if CMS no longer believes that the CO-OP is viable and sustainable and able to serve the interests of its community, CMS should pursue all available remedies for recovery of funds from CO-OPs. This would include the option to terminate loan agreements, which would require the CO-OP to forfeit all unused loan funds. This may allow CMS to recover

[3] In response to OIG's July 2015 report recommendations, CMS concurred with all four and noted that it has taken steps to further oversee CO-OP compliance by requiring external audits, site visits, and additional financial reporting.

[4] Loan Funding Opportunity Number OO-COO-11-001 was released July 28, 2011, and revised effective December 9, 2011.

[5] Sections 11 and 12 of the CO-OP loan agreement.

some portion of the loan, with the recognition that a CO-OP must resolve any outstanding debts or other claim obligations before repaying the loan funds to CMS.[6]

To ensure that CMS can appropriately identify CO-OPs that pose a high risk of failure, CMS should establish guidance or criteria to assess whether a CO-OP is viable or sustainable. In our July 2015 report, we found that low enrollments and net losses could limit the ability of some CO-OPs to repay startup and solvency loans and to remain viable and sustainable. Given the growing concerns about the financial viability of CO-OPs, it is critical that CMS provide the necessary guidance to improve program oversight and protect taxpayer dollars from significant losses.

Beyond enhancing its oversight with the tools available under the CO-OP loan agreement, CMS should also work closely with State insurance regulators who are the primary regulatory entities that oversee CO-OPs as health insurance issuers. This recommendation is important because it would allow CMS to obtain timely insights as to the CO-OPs' performance so that CMS can work with CO-OPs to address and fix ongoing financial and operational problems earlier. Financial concerns identified by State Insurance officials in Iowa and Tennessee led to significant actions to liquidate the operations of the Iowa/Nebraska and Tennessee CO-OPs. However, CMS did not terminate the Iowa/Nebraska CO-OP loan agreement until after the Iowa State Insurance Commissioner took control of the CO-OP because of financial concerns.

CONCLUSION

We appreciate the Subcommittee's interest in this important issue. We continue to urge CMS to fully address OIG's recommendations related to improving oversight and financial solvency within the CO-OP program.

OIG is committed to continued oversight of this program. Our ongoing work will assess whether CO-OPs were in compliance with Federal regulations and program requirements in managing Federal funds. In addition, OIG will reassess the CO-OPs' financial status to determine if any improvements were made in 2015 and identify actions CMS has taken to effectively oversee the loan program and monitor underperforming CO-OPs. We anticipate issuing these reports in 2016, and we look forward to sharing those results with the Committee at that time. This concludes my testimony. I would be happy to answer your questions. Thank you.

[6] Sections 4.4, 5.6, and 16.3 of the CO-OP loan agreement.

Mr. COLLINS. Thank you.

I'll now recognize myself for 5 minutes, and I guess, Ms. Cohen, I'm just going to start and accept you at face value when you say CMS does consider themselves responsible stewards of taxpayer dollars. Today's hearing kind of begs the question whether that's totally accurate or not. Before I get into a couple of other questions, there have been comments made that would somehow try to correlate states that did not increase, expand Medicaid to some of these failures on CO–OPs, and I guess I would just point out for the record, New York State absolutely aggressively expanded Medicaid, actively promoted ObamaCare, probably more so than most any other state in the country, and the hearing today is recognizing the failure of a CO–OP that was oversubscribed—not undersubscribed—and cost the taxpayers over $250 million, which is almost 25 percent. So I don't know that some of these other comments would accurately portray the problem. I'll just go back to the products were underpriced from day one, and if you underprice your product, there will be a price to pay.

So, Ms. Cohen, my worry now about New York and the loss of $250 million plus—Dr. Cohen, sorry—that it appeared that the New York CO–OP was in distress right from the beginning, lost over $35 million in the first year. I'm assuming you're aware that there was an additional loan of $91 million after they lost $35 million, so could you speak to what that rationale was that the taxpayers now lost another $91 million?

Dr. COHEN. Sure. As we looked at the CO–OP program over the first few years, I think you have heard a lot about the early years having uncertainty. We're still in that. We're only in the second year of the program in terms of folks facing a number of challenges. When any CO–OP approached us with any additional requests for funds, we evaluated that on an individual basis as we did even the startup of any one of these companies. We looked at their financial health at that time, their projection of where they were going to go, how they intended to get to a place of good standing, again, to say that we want to be good stewards of taxpayer dollars and want to be sure that if we are going to be further investing in a company, that we are going to be seeing those dollars. So we can only look at the information we have on hand at that time. At that time, our independent expert panel who reviews these felt that a further investment in New York, in the New York CO–OP, was the right decision. And we moved forward with that investment. We continue oversight and information, and facts on the ground change, and we make different decisions as we move forward.

Mr. COLLINS. With that said, I would appreciate if you could provide the committee with the analysis that you indicate did occur that after losing $35 million in their first year, I have to presume that analysis would include such things as the difference in the, I would hope, much higher rates charged in 2015? Let me just start with that. They lost a lot of money in 2014, based on rates that weren't adequate to cover losses. Were the rates substantially increased the next year, like 20 percent or more?

Dr. COHEN. It's important to remember that CMS shares in partnership the oversight responsibility here, but the responsibility for

rate setting is done at the State level in the New York Department of Insurance, or DFS, in New York is the one primarily responsible for saying, are these rates adequate to cover the expenses?

Mr. COLLINS. And was that done?

Dr. COHEN. So they do their own rate review in New York. As you know, New York also runs its own exchange. So from our perspective at CMS, we do do oversight in terms of the financial stability of the program, according actually with how OIG recommended our additional enhanced oversight. But the rates themselves are set by New York, by the company, and then approved by the State Department of Insurance.

Mr. COLLINS. So do you know much the rates were increased for 2015?

Dr. COHEN. I don't have off the top of my head, but I know that they did request and were granted a rate increase for 2015.

Mr. COLLINS. I think it's just important to note again that it's a little concerning that CMS is making a $91 million loan based on what sounds like an analysis done by the New York State Department of Insurance, which ultimately was proven, by the fact that they're now shutting down, to have been totally bogus. So if you could share that information back with the committee, I think we could learn something from that.

Dr. COHEN. I would be happy to provide that.

Mr. COLLINS. I certainly appreciate that.

And Ms. Jarmon, my office will be sending you a letter to ask for even a more thorough investigation of what happened in New York State and what we may learn from the failures of the New York state CO–OP, and again thank you for that.

And, with that, I would recognize Ranking Member DeGette for 5 minutes.

Mr. DEGETTE. Thank you so much, Mr. Chairman.

I want to thank our witnesses for coming today, and I want to start with the risk-mitigation mechanisms in the law, which we commonly refer to as the three Rs, as I mentioned earlier. Those were designed to promote competition and ensure stability in the insurance marketplace. Is that correct, Dr. Cohen?

Dr. COHEN. That's right.

Mr. DEGETTE. And yet some would argue that those programs are what have led to the insolvency of the CO–OPs. I don't really understand how programs that were designed to help the CO–OPs could wind up hurting them. Let me go into that a little bit. The risk adjustment program is designed to transfer funds from lower risk programs to higher risk programs. Is that correct, Dr. Cohen?

Dr. COHEN. The risk adjustment program is designed to again make sure that companies are taking care of the people who really need the care, those that are sick, and making sure they're not just cherry picking the healthy folks but really offering coverage to anyone who walks through the door.

Mr. DEGETTE. What that does then is it transfers money then from lower risk plans, where there aren't so many severely sick people, to higher risk plans. Right?

Dr. COHEN. That's right.

Mr. DEGETTE. Given that, how is it that the CO–OPs wound up owing money to big insurance companies through the risk adjustment program?

Dr. COHEN. Right. So the risk adjustment program is not based on size. It's agnostic to size, but as you point out, what it's really looking at the math formulas focused on the total risk and the health of the population.

Mr. DEGETTE. So there was nothing in the statute to target not for profit or profit?

Dr. COHEN. No. It's agnostic as to——

Mr. DEGETTE. Was that the intention of the program. Do you know?

Mr. DEGETTE. It was intended to be a risk program for all of the insurers that participated in the marketplace.

Mr. DEGETTE. Now, the risk corridor program also ended up not coming through to the CO–OPs as we learned very painfully in Colorado in the last couple of weeks, and some State insurance commissioners, including mine, made management decisions based on the CO–OP's inability to deal with losses, so I want to ask you some questions about that. The 2015 CR/Omnibus legislation made it so insurer payments into the risk corridor program are the only source of funding to reimburse claims, effectively making the program budget neutral. Is that correct, Dr. Cohen?

Dr. COHEN. It is a mathematical formula that decides the proration rates or the ins and outs of that program, but yes, you're correct.

Mr. DEGETTE. I'm correct. Thank you. Now, in July of 2015, couple months ago, CMS reiterated to state insurance commissioners that they, "anticipate that risk corridor corrections will be sufficient to pay for all risk corridor payments." Is that correct, Dr. Cohen?

Dr. COHEN. That's correct.

Mr. DEGETTE. And yet just a few weeks ago, CMS revealed it would only be able to pay 13 percent of the reimbursements that the CO–OPs are owed. Is that correct?

Dr. COHEN. That's right.

Mr. DEGETTE. So why is that?

Dr. COHEN. As I mentioned, that formula is based on information that we got from the issuers themselves. That was not information that CMS had prior to the month of September. Originally, that data came in, as you may know, over the course of the month of July, and it was actually so messy we needed issuers to resubmit it.

Mr. DEGETTE. But see, here's the problem. In July, you're saying it's going to be sufficient to cover all risk corridor payments, and then, in October, you're saying, oh, it's only 13 percent. So irrespective of whether you had the data, you had CO–OPs like the one in my State with 83,000 people in it, who were relying on that. I guess it was bad information.

Dr. COHEN. I think it's important to remember that the risk corridor is one of three, ours as you mention, and in the reinsurance program, we actually paid 25 percent more than we thought we would be able to pay. Again——

Mr. DEGETTE. But, again, if you have a CO–OP that's on the edge, that didn't solve that problem. I'm running out of time. I just want to ask you a couple of questions. Do you think that you can do anything to give more certainty to this program without statutory changes? Yes or no?

Dr. COHEN. Could we give more certainty to the program?

Mr. DEGETTE. Can you make changes that would give more certainty to these CO–OPs so they could stay in business without statutory changes?

Dr. COHEN. I think we are always looking for opportunities.

Mr. DEGETTE. If you can supplement your responses by giving us the ideas. Do you believe that there are statutory changes that Congress could pass to give more certainty?

Dr. COHEN. I think that there are opportunities, yes, for——

Ms. DEGETTE. And that would be helpful if you would supplement that too.

Thank you very much, Mr. Chairman.

Mr. COLLINS. Yes. I thank the ranking member for her comments.

We'll now turn to Dr. Bucshon for 5 minutes.

Mr. BUCSHON. Thank you, Mr. Chairman.

And I thank the witnesses for being here.

So, Dr. Cohen, who ultimately made the decision to give out $91 million to New York, as was said; $66 million to Minutemen Health; $65 million to Kentucky Health CO–OP? I can go on, but three of—there's a few more, but three of the six that I have listed here failed. So I want to know the person that made the decision to give them the money.

Ms. COHEN. So we had a very rigorous process with an outside——

Mr. BUCSHON. Here's the thing. I know you've already described your process. I understand you have outside people that look at all the data. But what I want to know is someone put their signature on the loan from CMS and said: We're giving them this money. Who did that?

Ms. COHEN. I don't know who signed the loan agreements, but I can get back to you——

Mr. BUCSHON. Was it you?

Ms. COHEN. It wasn't me, sir.

Mr. BUCSHON. I didn't expect it would be.

Ms. COHEN. I can let you know and——

Mr. BUCSHON. Yes, I'm sure you'll have every intention of doing that, but I can tell you as a Member of Congress with experience asking these questions that I'll never find the answer to that because no one's going to take that responsibility, and I understand that. But do you know if it was a political appointee or a full-time CMS staff?

Ms. COHEN. I don't know who signed the loan agreements, but, again, I can talk more about the process that we went through in terms of evaluating the information that we had understanding the——

Mr. BUCSHON. Yes, I understand.

Ms. COHEN. But we can get you that information.

Mr. BUCSHON. Dr. Cohen, you also testified before Ways and Means, and they asked when CMS knew the CO–OPs would fail. And it says you didn't really give a clear answer. So I'm going to ask it. When did CMS know these CO–OPs would fail?

Ms. COHEN. We have been doing oversight of the CO–OP program since its inception. And each circumstance is very unique. And there were different periods of time where we had information in front of us. When we knew folks were potentially going down the wrong path, we put folks in enhanced oversight, on corrective action plans, and as information presented itself, again, we took action. We really are still in the very early stages of this program. And I think from the discussion today you could see that we have taken our oversight responsibilities very seriously. We do feel like we are trying to be the best stewards of taxpayer dollars as possible.

Mr. BUCSHON. I am going to run out of time. Is there political pressure to keep these CO–OPs alive?

Ms. COHEN. Sir, I would say we are trying to do our best job possible to make sure that consumers can know that if they go to the marketplace now and want to sign you for the CO–OP, that they are strong and stable. And that we have done a tough job here. I think if there was another way that we could have arrived here, we would have. But we've been doing some tough work. Again——

Mr. BUCSHON. OK. That doesn't answer the question, but I understand that.

Why do we need the three Rs?

Ms. COHEN. So——

Mr. BUCSHON. Because, like I think Mr. Collins pointed out, if I was going to start a business out there somewhere, I wouldn't rely on the three Rs to make sure that if something didn't work out, I all of a sudden got a check from the Federal Government. So fundamentally I get it, but, first of all, answer this question real quickly: CMS has always said they intended the risk corridor Program to be budget neutral. Is that correct?

Ms. COHEN. So all of the three R programs——

Mr. BUCSHON. No. That question specifically. Did CMS always intend for the risk corridor to be——

Ms. COHEN. I don't know if always. I would have to get back to you on that. I don't know if——

Mr. BUCSHON. OK. Because that's what it says here on my paper.

Ms. COHEN. I don't know if that wasn't something——

Mr. BUCSHON. So then you can go into why we need the three Rs in the first place. And I may know that may—I understand you didn't make these decisions, but you're here and so——

Ms. COHEN. Happy to answer. So the programs were based on our experience with the Medicare part D program, the drug program in Medicare that had those three similar programs. As you stand up any new market, there is uncertainty. We've been hearing about a lot of that uncertainty earlier today. And so, again, those programs, one, we wanted to make sure that sick people weren't somehow not covered by the insurance. We want those folks to be covered. The reinsurance program specifically was to cover the cost of any high-cost enrollees in early years. We know there may have been pent-up demand as——

Mr. BUCSHON. So it's basically to capitalize the business. Right? So that they have the capital to get off the ground.

Ms. COHEN. I think it's to keep premiums stable for consumers——

Mr. BUCSHON. OK. And following up on what Ms. DeGette said, you thought earlier in the year that you were going to be able to make the payments, and then you found out in October that you couldn't. And basically what's the reason for that?

Ms. COHEN. Honestly, it's the math formula. It's the way the data came in from the issuers. And that's the way the math worked out. And so we were able to pay at 12 percent, which is the dollars coming in, dollars going out. And that's the way we move forward for this program. We've always said that we will take from next year's collections and pay back to this year. It is a 3-year temporary program.

Mr. BUCSHON. OK. Thank you.

And I yield back.

Mr. COLLINS. Thank the gentleman for his questions.

Now recognize Mr. Yarmuth for 5 minutes.

Mr. YARMUTH. Thank you very much, Mr. Chairman. Welcome to the witnesses.

I can help Dr. Bucshon out a little bit on the background of the CO–OPs. One of the problems, we faced when we were drafting legislation was that in certain states, the availability of private insurance was limited to one provider. Or I think, in Alabama, there was Blue Cross Blue Shield dominated over 90 percent of the market. And in many states, that was the situation—maybe not that high. But the idea was to create competition, and the only way you could do it was to create a new entity. We chose CO–OPs as a nonprofit. And the idea was that you could that way create the kind of price competition that was meaningful.

But we knew, and we knew in Kentucky when the CO–OP was established—and I talked with them many times as they were getting started—that they had no idea what kind of an insured population they were going to have. They didn't know what the age was going to be. They had no data to predict that. They didn't know how many would enroll. They didn't know how many would have never had any healthcare, so automatically once they became insured, they would have a rush of care. They would try to get tests and because they—or treat things that they had never been able to treat before or whether they were going to get people who had had medical care but just lost their insurance. So the unpredictability of it was certainly the rationale for that. And I'm really proud of the experience with ACA in Kentucky. We have led the country in the reduction and in the amount of uninsured. More than 50 percent of our previously uninsured are now covered, more than 520,000 people in a state of 4.4 million. And in my district alone, in Louisville, we've reduced the uninsured rate by 81 percent, an astounding accomplishment. And more importantly than that, I think, is that every day I'm hearing from people who now have insurance and had a family member or a neighbor or friend whose life has been saved because they had insurance that they otherwise wouldn't have. And I could talk about that for a long time.

But the focus of this hearing is on the CO–OPs. And I want to try and set the record straight about what happened with Kentucky.

Ms. Jarmon, unlike most of the CO–OPs reviewed by your office, is it your understanding that the Kentucky Health Cooperative had far higher enrollment than expected, nearly double their original projections?

Ms. JARMON. We actually have a chart in our report on the enrollment projections as of 2014, and for Kentucky, yes, it was like 183 percent. So that was right. It was one of the few that was——

Mr. YARMUTH. And is it your understanding that a very high percentage of those enrollees were much sicker or utilized much more care than—and therefore were more expensive to ensure than the general population?

Ms. JARMON. I don't have that——

Mr. YARMUTH. You don't have that information.

Well, again, that's why we established this risk corridor program and why it was so important. And that's what happened to Kentucky's CO–OP. They relied on this. Kentucky's CO–OP, as I mentioned before the earlier panel, lost $50 million in its first year. In the second—first half of 2015 that loss had slowed down to a rate of 4 million. They were on track to make a profit in 2016, and unfortunately, when the risk corridor program was by that 87 percent, they were unable to continue.

Dr. Cohen, is it your understanding that had Congress not capped the payments for the risk corridor program, that Kentucky Health Cooperative would still be open for business?

Ms. COHEN. No. I think that there were a number of factors that contributed. Obviously, that was one of the last and certainly we have heard was an important factor for them. But you have to know that there were many factors, as we've been talking about all along in terms of the uncertainty and the challenges for the CO–OP program.

Mr. YARMUTH. And as I mentioned before, that having been said, is it your understanding that even without the CO–OP, Kentucky residents will still have more health insurers to choose from in 2016 than they had——

Ms. COHEN. Yes.

Mr. YARMUTH [continuing]. In prior years?

Ms. COHEN. Yes, very exciting.

Mr. YARMUTH. Yes. So, again, I think I could talk for a long time about the success of the Affordable Care Act in Kentucky. We're a much healthier state because of it. And I know somebody threw around a figure that maybe the approval rating of the Affordable Care Act is down near 20 percent. In Kentucky, it's well over 50 percent.

Ms. COHEN. And I'll give you a new number that the CDC just put out today for a new reduction in the uninsured rate to 9 percent historic. So I appreciate your leadership on that.

Mr. YARMUTH. Thank you, Dr. Cohen.

I yield back, Mr. Chairman.

Ms. DEGETTE. Mr. Chairman, can I take a moment of personal privilege?

Mr. COLLINS. Yes. Absolutely.

Ms. DEGETTE. You might have noticed this is not one of the new Members of Congress here. This is a dear, dear friend of mine and Chairman Upton's, Max. And Max has been helping us with our 21st Century Cures bill. Most of the staff and members have met him. Last night, Max was very honored to receive an award at the Every Life Foundation for Rare Diseases, Rare Voice Awards gala reception. And also Chairman Upton and I received awards, but Max is the one. He's why we're doing this. So thanks for letting me——

Mr. COLLINS. Oh, no. Thank you. And we all welcome Max. When I look back to the unanimous vote out of our committee on 21st Century Cures, I can tell you Max whipped more than one vote.

Ms. DEGETTE. Max is our secret weapon.

Mr. COLLINS. We may be looking at a future majority whip here sitting next to us.

With that, I'd like to recognize Mrs. Blackburn for 5 minutes.

Mrs. BLACKBURN. Thank you so much.

And thank you for our witnesses and for your patience today. We appreciate it.

I'm sorry that Mr. Yarmuth left. I think it's important to note in Kentucky, when Tennessee had TennCare, a lot of Kentucky residents were coming into the state to try to get healthcare. And the Kentucky CO–OP did close. And the Kentucky approval rating of the ObamaCare products that are in the marketplace is really quite low, as was evidenced in that state this week.

Ms. Cohen, I want to come to you. I had Commissioner McPeak here. I don't know, were you in the room for the first panel?

Ms. COHEN. I was.

Mrs. BLACKBURN. OK. I'm really concerned about what has happened with taxpayers and the liability there with what took place with the loans and then the solvency grants. And we all should be concerned with that. That is not your money to give away. It is taxpayer money. And this is just money down the hole it appears because this didn't work. And to go in here and hear from the CO–OPs that they now have these loan conversion options and that these startup loans classified as assets rather than debt, and I don't see how you get there. Doesn't that type loan conversion really give a false picture of what is going on in that CO–OP? Is that not a falsehood?

Ms. COHEN. So, when talking about those conversions, which is what some of the CO–OPs have approached CMS with, we evaluated each of those on an individual basis. And I think you heard Ms. McPeak mention that in that case that was not the right step forward. And we did not go——

Mrs. BLACKBURN. To have suggested that, is that not giving an inappropriate picture of the financial stability of that CO–OP?

Ms. COHEN. So that was a request by the CO–OP to CMS. We did evaluate whether or not that was the right——

Mrs. BLACKBURN. So you looked at whether they could call debt an asset.

Ms. Jarmon, let me ask you. In the business world, the private business world, I think if you did that, you'd be accused of fraud, if you started re-characterizing your debts as assets and putting them on your balance sheet as an asset. I have just never even

heard of somebody saying that the Federal Government would approve such a process. How do you all view that?

Ms. JARMON. I believe that came out in guidance in July of this year. So it was after we had done our work. We will be looking at it, but——

Mrs. BLACKBURN. You're going to go back in and review that?

Ms. JARMON. Yes, we will look at it as part of our follow-up. It was part——

Mrs. BLACKBURN. Well, we will appreciate getting that. Is that not an odd business practice? I've never seen this type characterization viewed as being a standard operating procedure.

Ms. JARMON. It appears unusual. Right.

Mrs. BLACKBURN. It does appear unusual. And I think that it leads us, Ms. Cohen, to wonder if there are other unusual business practices that are surrounding the stability of the CO–OPs or the lack of stability of the CO–OPs and the entire lack of stability of the Affordable Care Act programs. This is highly unusual.

Vermont Health CO–OP, $33 million in Federal loans had been awarded to the Vermont Health CO–OP. How much, if any, of the money for the Vermont Health CO–OP has been or will be returned to the Federal Treasury?

Ms. COHEN. We work aggressively, if we are winding down any CO–OP, to return funds back to the taxpayer.

Mrs. BLACKBURN. How much has been returned?

Ms. COHEN. I don't have the number——

Mrs. BLACKBURN. Would you get that number for us?

Ms. COHEN. I will do what I can.

Mrs. BLACKBURN. When money is awarded and then they don't get the license to stand up the CO–OP, every penny of that ought to be coming back to the Federal Treasury. And I think you know that.

Ms. COHEN. We work aggressively to recover the loan funds in——

Mrs. BLACKBURN. I can imagine what the IRS would say if people would: Well, we're going to work to get that money back to you, IRS. We're really working on it.

So we want to see that that comes back. Because I think it is inconceivable that the taxpayers are going to be held responsible for this.

And when should we expect that money? What's your timeline for getting that money back in?

Ms. COHEN. So we're working through that process right now. I don't have——

Mrs. BLACKBURN. So you've got all this money out here. Ms. Cohen, listen to yourself. You got all this money out here. It is being wasted. Half of your CO–OPs are insolvent, and you've got this re-characterization process going to take your debts and make them appear to be assets. That is highly unusual. And you want to sit here and say: Well, we're looking at it?

When are you doing it? Are you continuing to meet on it every week? Do you have a timeline for coming up with getting this money back? Is it a top priority?

Ms. COHEN. So my team——

Mrs. BLACKBURN. Yes. Please read the note that's been passed to you.

Ms. COHEN. So we got all of the money back from Vermont, which—I would say the rest of the CO–OPs that we've been working with over the last several months, obviously, are still in business. They continue to provide coverage for consumers until the end of the year. And then we'll work through the process at that point in accordance with the loan agreement to recover funds for the taxpayer.

Mrs. BLACKBURN. OK. So there is something in process. Thank you.

Ms. COHEN. Thank you.

Mrs. BLACKBURN. And if you will continue to provide that type of information for us, that is what we need to know, the specifics. It does not help us in doing our due diligence and being certain that people have coverage, it does not help us if you come into a hearing and you cannot say: This is where we are, exactly where we are, and what we're going to do. It is helpful when Ms. Jarmon says: This happened after our July review, and then we're going to come back in and we're going to look at this very unusual business practice and have a recommendation for you. That's the kind of thing that is helpful.

I am way over my time. I yield back.

Mr. COLLINS. That's OK. We are missing a lot of our members. So we'll actually maybe ask a few more questions, to dig down a little bit deeper.

And, again, I'd like to kind of just set the stage. All of us up here agree we need to be good stewards of taxpayer money. And that's the purpose of this hearing. Learning from what's happened the last 2 years, and losses have occurred, it sounds like a few CO–OPs are doing OK. Half of them failed. There's lessons to be learned here. And I think the purpose of this hearing and our requests for more information will be: How can we take all of that and hopefully not continue to lose taxpayer money?

But, Ms. Jarmon, there is a question for OIG that the loan agreements, as I understand it, between CMS and the CO–OPs do have provisions in them, enforcement provisions, and I just wondered, could you explain what some of those provisions might be. And then a very direct question would be, to the best of your knowledge, and then I'll go to Dr. Cohen, have we taken any of these enforcement measures against any CO–OPs?

Ms. JARMON. Right. The loan agreements do allow—there's an option to terminate the loan agreements which would require the CO–OP to forfeit all unused loan funds. And there's also within the loan agreement and the funding opportunity, there's the issue of the enhanced oversight plans and corrective action plans, which CMS has actually put several of the CO–OPs under enhanced plans and corrective action plans. So those are all part of the loan agreement.

Mr. COLLINS. Has CMS terminated any loan agreements?

Ms. JARMON. I am not aware.

Dr. COHEN. So we have terminated the loan agreements for those 12 CO–OPs that you have heard that are shutting down. So we have terminated all of those, and we will——

Mr. COLLINS. Did we get any money back?

Ms. COHEN. So let me clarify, and I want to make sure for the record I have it right. So, in Vermont, we did get the vast majority of the money. There was some funding that was used in their start-up funds that was not recovered. On a go-forward basis, we are making sure that consumers have coverage through the end of the year. These entities will be operating through the end of the year. And at that time, we will do a run-out of claims and understand the financial health of the organization and then use all of our ability with the terms of the loan agreement to recover——

Mr. COLLINS. Now, but that's not the case in New York. They're not running—it's my understanding—the CO–OP in New York, which lost $250 million in fact is shutting down in 2 weeks' time. So that doesn't——

Ms. COHEN. That's right.

Mr. COLLINS [continuing]. Line up with what your testimony just was.

Ms. COHEN. That is right. So that is why we are doing so much of the hard work right now before this open enrollment period started on November 1 to make sure we understood the financial health of any one of these CO–OPs, is because we want consumers to be confident that there wouldn't be a midyear closure of any one of these CO–OPs.

In the case of New York, we went to wind them down and terminate their loan agreement back in the September timeframe when we sent in our audit team after we even decided to wind them down. We went and found out that their financial situation was even more dire than we understood it to be when we made the decision to wind them down, and that is why we are in this unfortunate situation. I will say that the folks in New York, the Governor's Office, the Department of Insurance, has jumped on this problem and is working it very aggressively to make sure consumers have a smooth transition. And this is exactly why we're doing all of this tough work right now so this doesn't happen in other places.

Mr. COLLINS. I purchased a lot of distressed companies in my private sector career. And let me tell you, a bank who then loans money in many cases in what you might call workout or asset-based lending agreements, there's literally daily and weekly reports. And you are under a magnifying glass until that bank who has money at risk is confident that they're going to be able to be paid back. And it, quite frankly, sounds as though CMS has accepted a lot of information at face value, and not dug very deeply into those details to say: OK, 2 months later, we're totally shocked the finances are much worse. If somebody was really watching a $250 million loan, day by day and week by week, I don't think you would wake up 2 months later you would have found out 2 months earlier, and maybe we would have lost $200 million instead of $250 million. I think there's lessons learned in that, when you're good stewards of taxpayer money, the taxpayers expect a level of scrutiny at least consistent with what big banks do when they make loans. And, in fact, you could argue maybe it should even be more than that.

So my last few seconds here, another question, I know that there's going to be outstanding claims, as these CO–OPs are shut-

ting down, including New York. I'm assuming there's no money. Who's going to pay those claims?

Ms. COHEN. So, as I said, the CO–OPs continue to wind down over the course of this year, and they do have funding that——

Mr. COLLINS. So like take New York. Is there enough money in——

Ms. COHEN. So New York is a different circumstance where they need to wind down by November 30 and then run out those claims after——

Mr. COLLINS. And they'll have enough money to pay all those?

Ms. COHEN. So one of the big things that we did in partnership with the State Department of Insurance is make sure that they go into receivership. And by doing that, we are able to have better control over their finances and the claims payout as well as——

Mr. COLLINS. Do you feel as though there will be enough money to pay out? If there's not, is the government going to make the provider, that—now there's no money. How do they get paid?

Ms. COHEN. So we're working—and as you said, it's a day-by-day type of situation. We're watching very closely to make sure we can——

Mr. COLLINS. Could there be more taxpayer moneys having to go in as this is wound down?

Ms. COHEN. Our primary goal is to protect the consumer and the——

Mr. COLLINS. It should be. Right.

Ms. COHEN [continuing]. And the taxpayer. So we're going to do everything possible to make sure that we can have a smooth transition. That's a partnership between ourselves and the New York State Department of Insurance. We're working collaboratively in that process to make sure that that——

Mr. COLLINS. Well, and we would encourage you to continue to do that. And thank you for your testimony.

I'd like to see if Ranking Member DeGette has a few follow-on questions.

Ms. DEGETTE. Thank you, Mr. Chairman. I want to go back to something that Mr. Morrison said in the previous panel. When we set up the insurance CO–OPs under the ACA, we set them up to help give people who were sicker, who were poorer, who had less of a choice, a choice of an insurance plan. And as we all know quite clearly, the CO–OPs don't have a lot of the same benefits as private insurance companies. They don't have the kind of capitalization from other products and so on. Wouldn't that be a fair statement, Dr. Cohen?

Ms. COHEN. Yes. They face a number of those challenges.

Ms. DEGETTE. Right. And so when you're just starting up some CO–OPs, it's not like you're a private company saying: OK, let's offer this new product and if it takes us a few years, we can do that. So I really think that the comparison of the CO–OPs to a private business is a little unfair. And that's why I think we set up these three Rs, to try to help the CO–OPs get established and then the concept, Dr. Cohen, was that they would become self-sufficient and they would be able to sustain their business model. Is that right?

Dr. COHEN. I think that those programs were set up to help the entire market transition, CO–OPs among them.

Ms. DEGETTE. OK. And so I guess I was a little concerned when I heard you say earlier that you were reviewing all of the states' situations on an individual basis. And here's why. And I saw this from my end being in Congress where my state thinks in July that the money's going to be sufficient for risk corridor payments. Then they hear in October that, no, that's not going to happen. And they have a real degree of uncertainty with how CMS is viewing that state CO–OP, whether it's—how they're viewing their capitalization, how they're viewing their viability. And they don't know day to day whether they're going to be able to offer a product in open enrollment period that starts on November 1. So the concern that a lot of us have is where you don't have some kind of a bright line rule, the uncertainty in those states is really contributing to instability in the whole insurance market in those states. I assume you understand those points I'm making.

Ms. COHEN. Absolutely.

Ms. DEGETTE. And so I'm hoping that you and your staff would be willing to continue to meet with our committee staff on both sides of the aisle to help us figure out how we can help you get some certainty so that we don't have situations where states like New York and Colorado are suddenly going out of business just a few weeks before the open enrollment period, the other providers, including private insurance companies, are scrambling to try to figure out how to absorb this, and the 83,000 people in Colorado, I'm sure it was—I don't know how many it was in New York, but, you know, this is affecting real lives. And I know you realize that, but I think it would be really helpful if we could get much more clear standards going forward.

Ms. COHEN. Understand.

Ms. DEGETTE. Thank you, Mr. Chairman.

I yield back.

Mr. COLLINS. Thank you. And it was 155,000 in New York.

As we conclude this hearing. I would ask Dr. Cohen if we could get a commitment out of CMS to provide that analysis that resulted in the CMS awarding additional funds to New York's CO–OP and some others the end of 2014.

Ms. COHEN. I will work with the staff to get it confirmed.

Mr. COLLINS. Thank you. And also if you could commit that CMS will provide us any CO–OP corrective action plans that may exist. I mean, as you've done this analysis, could you forward those to the committee?

Ms. COHEN. I'll have to look and see. Some of those are market-sensitive. But we will do our best to get what we can to the committee.

Mr. COLLINS. I thank you for that. And then also I'd like to enter into the record a Wall Street Journal article that does have a quote from CMS that risk corridors were intended to be budget neutral. And I'd ask unanimous consent to enter this into the record.

So moved.

[The information appears at the conclusion of the hearing.]

Mr. COLLINS. As we conclude our hearing, again, I want to, first of all, also say that we would ask unanimous consent that members' written opening statements be introduced into the record.

And, without objection, those documents will be entered into the record.

And I'd like to thank our two witnesses for your comments, as we all want to work together to, again, be good stewards of taxpayer money.

And I would like to remind members they have 10 business days to submit questions for the record. And I ask that the witnesses all agree to respond promptly to those questions.

And, with that, this meeting is adjourned.

[Whereupon, at 2:03 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Hardworking taxpayers loaned $2.4 billion to Obamacare's CO–OP program, which was intended to create new non-profit health insurance insurers to increase choice and competition. Unfortunately for both taxpayers and consumers, it has been a mess with 12 out of the 23 COOPs having failed. That's a success rate of 48 percent. Sadly, taxpayers are once again on the losing end as the 12 failed CO–OPs cost $1.23 billion.

The CO–OP program faced an uphill battle from the outset. In fact, as early as 2011, HHS predicted that only 65 percent of the solvency loans and 60 percent of the start-up loans would be repaid. And those predictions might be considered rosy since they have done far worse. The statute and CMS regulations and policies have seemed to hamper the CO–OPs ability to succeed. For example, CMS has prohibited CO–OPs from raising capital from outside investors and capping enrollment numbers.

We have witnesses today who will offer valuable testimony, sharing unique perspectives and experiences with the CO–OP program, including state insurance regulators, CMS, OIG, and of course, the CO–OPs. We have many questions, and the American public deserves answers. The committee wants to understand why do these CO–OPs continue to shut their doors? What can CMS do to help COOPs succeed? What can the administration do to recoup these vital taxpayer dollars from the failed CO–OPs? And what plans did the administration have in place to protect taxpayer dollars in light of HHS' initial pessimistic predictions for the program?

Regardless of one's view of the president's health law, the law itself and its implementation demand oversight. It seems that the news gets worse by the day, with more and more taxpayer dollars squandered. The CO–OP program has sadly followed the same script. With 12 out of 23 having failed at a loss of over $1.23 billion, who is taking responsibility and being held accountable?

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

November 2, 2015

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing entitled "Examining the Costly Failures of Obamacare's CO-OP Insurance Loans"

On Thursday, November 5, 2015, at 10:00 a.m. in 2322 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled "Examining the Costly Failures of Obamacare's CO-OP Insurance Loans."

Section 1322 of the Patient Protection and Affordable Care Act (ACA) established the Consumer Operated and Oriented Plan (CO-OP) program. Under the program, the Secretary of Health and Human Services (HHS) was authorized to provide loans to create new non-profit health insurance issuers, intended to increase choice and create competition among insurers. Although Congress initially allotted $6 billion for the program, subsequent legislation rescinded over half of the initial funding, leaving $2.4 billion for the program. The Centers for Medicare and Medicaid Service (CMS) funded 23 CO-OPs, not including Vermont's CO-OP, which dissolved before open enrollment began. Of the 23 CO-OPs that sold health insurance plans, 11 have closed to date; these 11 CO-OPs represent over $1 billion taxpayer dollars.

I. WITNESSES

Panel One:

- Ben Sasse, Senator, Nebraska.

Panel Two:

- Julie McPeak, Insurance Commissioner, Tennessee;
- James Donelon, Insurance Commissioner, Louisiana;
- Peter Beilenson, Board of Directors, National Alliance of State Health CO-Ops; and
- John Morrison, Vice Chair, Montana Health CO-OP

Panel Three:

- Mandy Cohen, Chief of Staff, Centers for Medicare and Medicaid Services; and
- Gloria L. Jarmon, Deputy Inspector General for Audit Services, Office of Inspector General, U.S. Department of Health and Human Services.

II. BACKGROUND

Section 1322 of the Affordable Care Act

The ACA established health insurance marketplaces in all 50 States and the District of Columbia to facilitate the purchase of health insurance by individuals and small businesses as required under the law.[1] Section 1322 of the ACA established the CO-OP program, envisioned as an opportunity to give consumers more choices in their healthcare plans and increase competition among insurers.[2] According to HHS, CO-OPs were designed to be "directed by their customers and designed to offer individuals and small businesses additional affordable, consumer-friendly, and high-quality health insurance options."[3]

CMS awarded $2.4 billion in government-backed loans to the 24 CO-OPs established under the law, through two types of loans.[4] Start-up loans are designed to pay for the CO-OPs' beginning operations and must be repaid within five years.[5] Solvency loans are intended to enable CO-OPs to meet capital reserve requirements of the States in which the applicants sought a license to sell insurance, and must be repaid within 15 years.[6] CO-OPs must pay any outstanding debts or obligations before repaying the loan funds to CMS.[7] On January 1, 2014, 23 CO-OPs offered health insurance coverage through the new health insurance marketplaces in 23 States.

Before the CO-OP program was implemented by HHS, both HHS and the Office of Management and Budget (OMB) projected significant loss of taxpayer dollars because of government loans made through this program. HHS's 2011 proposed rule to implement the CO-OP program estimated that approximately one-third of CO-OPs would fail to repay their loans, predicting that only "65 percent of the Solvency Loans and 60 percent of the Start-up Loans"

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[1] Patient Protection and Affordable Care Act of 2010, § 1311 (2010).
[2] Patient Protection and Affordable Care Act of 2010, § 1322 (2010).
[3] Dep't of Health & Human Serv., Centers for Medicare & Medicaid Serv., Center for Consumer Information & Insurance Oversight, *Fact Sheet: New Federal Loan Program Helps Nonprofits Create Customer-Driven Health Insurers, available at* http://cciio.cms.gov/resources/factsheets/coop_final_rule.html (last visited Oct. 29, 2015).
[4] Dep't of Health and Human Serv., Centers for Medicare & Medicaid Serv., Center for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers, available at* https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html (last visited Oct. 29, 2015).
[5] 45 CFR § 156.520 (2012).
[6] *Id.*
[7] Office of Inspector Gen., Dep't of Health and Human Servs., Actual Enrollment and Profitability Was Lower Than Projections Made By The Consumer Operated and Oriented Plans and Might Affect Their Ability To Repay Loans Provided Under the Affordable Care Act, Audit no. A-05-14-00055 (July 2015).

would be repaid.[8] The following year, OMB projected taxpayers would lose over 40 percent of loans offered through the program.[9]

HHS OIG Audits

Given the concern about the long-term solvency of the CO-OPs, the HHS Office of the Inspector General (OIG) has conducted multiple audits of the CO-OPs participating in the program. In July 2013, an OIG audit identified factors that could adversely affect the CO-OP program, including limited private monetary support and budget startup expenditures that exceeded available funding.[10] The audit found that "11 of 16 CO-OPs reported estimated startup expenditures in their applications that exceeded the total startup funding provided by CMS."[11] The OIG audit warned that CO-OPs were at risk of exhausting all start-up funding before they were fully operational if certain circumstances occurred, such as low enrollment, uncertainty about operations of the marketplaces, and State's denial of licensure.[12]

An audit released by the OIG in July 2015 found that most of the 23 CO-OPs reviewed had not met their initial program enrollment and profitability projections.[13] In 13 of the 23 CO-OPs, member enrollment was considerably lower than the CO-OPs' initial annual projections, and 21 of the 23 CO-OPs incurred net losses from January 1, through December 31, 2014.[14] More than half of the 23 CO-OPs had net losses of at least $15 million for this period. The OIG explained that "low enrollments and net losses might limit the ability of some CO-OPs to repay startup and solvency loans."[15] The audit also provided insight into CMS's oversight mechanisms for the CO-OP program. According to the OIG, CMS had placed four CO-OPs on enhanced oversight or corrective action plans and two CO-OPs on low-enrollment warning notifications.[16] The OIG also noted that CMS may terminate the loan agreement if "the CO-OP fails to meet quality and performance standards, including implementation of milestones and enrollment targets as specified in the loan agreement or any other contractual obligation with CMS."[17]

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[8] "Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan (CO-OP) Program," 76 Federal Register 139 (20 July 20 2011), p. 43247.
[9] Office of Mgmt. & Budget, Exec. Office of the President, Budget of the U.S. Government, Fiscal Year 2013, Federal Credit Supplement, Table 1 (2012).
[10] Office of Inspector Gen., Dep't of Health and Human Servs., CMS Awarded Consumer Operated and Oriented Plan Program Loans in Accordance with Federal Requirements, and Continued Oversight is Needed, Audit no. A-05-12-00043 (July 30, 2013).
[11] *Id.*
[12] *Id.*
[13] Office of Inspector Gen., Dep't of Health and Human Servs., Actual Enrollment and Profitability Was Lower Than Projections Made By The Consumer Operated and Oriented Plans and Might Affect Their Ability To Repay Loans Provided Under the Affordable Care Act, Audit no. A-05-14-00055 (July 2015).
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] *Id.*

III. CONSUMER OPERATED AND ORIENTED PLAN (CO-OP) PROGRAM

Of the 23 CO-OPs initially established by HHS pursuant to the ACA, 11 have closed.

CO-OP	Award Amount	Date of Closure
CoOpportunity Health (Iowa/Nebraska)	$145,312,100	January 23, 2015
Louisiana Health Cooperative, Inc.	$65,790,660	July 24, 2015
Nevada Health Cooperative, Inc.	$65,925,396	August 25, 2015
Health Republic Insurance of New York	$265,133,000	September 25, 2015
Kentucky Health Care Cooperative (Kentucky/West Virginia)	$146,494,772	October 9, 2015
Community Health Alliance Mutual Insurance Company (Tennessee)	$73,306,700	October 14, 2015
Colorado HealthOp	$72,335,129	October 16, 2015
Health Republic Insurance of Oregon	$60,648,505	October 16, 2015
Consumers' Choice Health Insurance Company (South Carolina)	$87,578,208	October 22, 2015
Arches Mutual Insuance Company (Utah)	$89,650,303	October 27, 2015
Meritus Health Partners (Arizona)	$93,313,233	October 31, 2015

This total does not include Vermont's CO-OP, which was dissolved before enrolling a single person.[18] Despite receiving an award approved for over $33 million, Vermont's CO-OP failed to meet the State's insurance standards and was denied a license to sell health insurance.[19] Vermont's former Chief Executive has said it will be unable to repay $4.5 million that had been spent.[20]

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[18] Anne Galloway, *Feds Terminate Loan Agreement with Vermont Health CO-OP*, VT DIGGER, Sept. 16, 2013.
[19] State of Vt. Dep't of Fin. Regulation, In the Matter of: Application by the Proposed Vermont Health CO-OP for a Certificate of Public Good and Certificate of Authority to Commence Business as a Domestic Mutual Insurance Company, Docket No. 12-041-I (May 22, 2013).
[20] Jerry Markon, *Health co-ops, created to foster competition and lower insurance costs, are facing danger*, THE WASHINGTON POST, Oct. 22, 2013.

CoOpportunity, a CO-OP operating in Iowa and Nebraska, was the next CO-OP to fail after Vermont, and was taken over by Iowa insurance regulators in December of 2014.[21] CoOportunity launched in March 2013 and enrolled over 120,000 individuals, amounting to one fifth of CO-OP enrollees nationally.[22] Of the $145 million Federal loans CoOportunity received, $33 million were awarded in September 2014, just months before the State of Iowa took possession of the CO-OP's assets.[23] In March 2014, CoOportunity was liquidated, and an Iowa district court found that its operating losses were over $163 million and it had $50 million more in liabilities than assets.[24]

As it became apparent that many CO-OPs faced significant financial hurdles in late 2014, HHS awarded more than $350 million in additional loans to six CO-OPs: $91 million to Health Republic Insurance of New York, $66 million to Minuteman Health, $65 million to Kentucky Health Co-op, $51 million to Common Ground Healthcare Co-op in Wisconsin, $48 million to HealthyCT, and $33 million to CoOportunity.[25] Three of those six CO-OPs have since closed, and it is unclear whether taxpayers will recoup any of those dollars.

The 11 failed CO-OPs canceled health insurance for customers in 14 States: Vermont, Kentucky, Tennessee, Iowa, Nebraska, West Virginia, Colorado, New York, Louisiana, Nevada, Oregon, Utah, South Carolina, and Arizona. Seven of the 11 CO-OPs have closed their doors in just the last month, in anticipation of open enrollment which began on November 1, 2015.

IV. ISSUES

The following issues may be examined at the hearing:

- What factors contributed to the collapse of 11 CO-OPs to date?
- What are CMS' oversight mechanisms to monitor CO-OPs, and are they effective?
- What is the likelihood that the Federal government will recoup any of the loans awarded to failed CO-OPs?
- What steps can CMS, CO-OPs and State regulators take to help CO-OPs repay the loans and minimize loss to taxpayers?
- How does the closure of CO-OPs affect consumers?

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[21] Steve Jordan, *Troubled Iowa Insurer CoOportunity Health May be Liquidated*, OMAHA WORLD HERALD, Dec. 24. 2014.
[22] *Id.*
[23] Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, "Loan Program Helps Support Customer-Driven Non-Profit Health Insurers", December 16, 2014, https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html
[24] *State of Iowa, ex. rel. Nick Gerhart, Commissioner of Insurance v. CoOportunity Health, Inc.* Case Number EQCE077579, Final Order of Liquidation, March 2, 2015.
[25] Dep't of Health and Human Services, Centers for Medicare & Medicaid Serv., Center for Consumer Information and Insurance Oversight, "Loan Program Helps Support Customer-Driven Non-Profit Health Insurers", December 16, 2014, https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html

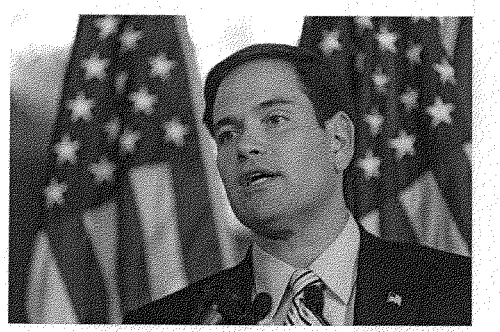
V. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Emily Felder, Jessica Donlon, or Brittany Havens of the Committee staff at (202) 225-2927.

WASHINGTON WIRE

Explaining 'Risk Corridors,' The Next Obamacare Issue

Jan 22, 2014 1:19 pm ET



Sen. Marco Rubio has introduced legislation to eliminate an Affordable Care Act program that c help insurers in the next few years. *ASSOCIATED PRESS*

By Louise Radnofsky and Jennifer Corbett Dooren

To one side, it's a massive bailout of insurance companies that could cost taxpayers billions of dollars. To the other, it's an important protection for consumers that might not cost anything.

Welcome to the debate over the "risk corridor" provision in the 2010 Affordable Care Act. With the federal HealthCare.gov website working better and millions of Americans signing up for new coverage, the once-obscure provision has taken center stage in efforts by Republicans to dismantle the law known as Obamacare.

The idea of risk corridors is to compensate insurance companies that end up with bigger costs than they expected. Under the law, they must sell policies equally to everyone, regardless of their medical history, so it's possible some insurers could end up with an especially unhealthy pool of customers.

If an insurer's actual claims in 2014 are at least 3% greater than the claims projected when the insurer set 2014 rates, the government must reimburse the insurer for half of the excess. If actual claims jump 8% beyond projected claims, the government covers 80% of the excess. (This fact sheet from the American Academy of Actuaries has a handy chart.)

Federal officials say they're counting on the program, which lasts through 2016, to forestall any nervousness among insurers about their initial customer base and prevent them from raising rates. They point to a similar plan put in place when Medicare was expanded last decade to include Part D coverage of prescription drugs.

"The temporary risk corridor provision in the Affordable Care Act is an

important protection for consumers and insurers as millions of Americans transition to a new coverage in a brand new marketplace. The policy, modeled on the risk corridor provision in Part D that was supported on a bipartisan basis, was estimated to be budget neutral, and we intend to implement it as designed," said **Aaron Albright**, a spokesman for the Centers for Medicare and Medicaid Services.

This Weekly Standard editorial lays out the conservative case against risk corridors.

"The insurers are counting on this massive bailout to avoid a bloodbath of losses from Obamacare," write **James Capretta** and **Yuval Levin**. "It is hard to imagine that many Americans, regardless of their political leanings, want taxpayers to be on the hook for covering the losses of shareholder-owned insurance companies."

The two writers say that the messy rollout of the law means that the government could end up on the hook for "hundreds of millions and perhaps billions of dollars." Scrapping the program or at least insisting that it be budget-neutral is the next step for people who want to unwind the law, they say.

Sen. **Marco Rubio** of Florida and Rep. **Tim Griffin of Arkansas**, both Republicans, are already pushing bills that would do that, and more could follow as Republicans look for issues to bring up in negotiations over extending the U.S. debt ceiling.

Exactly what the risk-corridor program will cost is open for debate because it also is designed to collect money from insurers that end up with a healthier-than-expected pool of customers. That is why Obama administration officials are saying it could be budget-neutral.

The importance of the program grew when President **Barack Obama** said in November that he wanted people to be allowed to keep old policies that would otherwise have been canceled. Insurers said the abrupt change could make the balance of risk worse by keeping healthier people out of the new exchanges set up by the Affordable Care Act.

In rules released just ahead of the Thanksgiving holiday, the administration said it was exploring ways to beef up the risk-corridors program in light of the president's move. The rules don't set out exactly how the program would change or what it would cost.

Two other parts of the law are also designed to smooth out imbalances in the risk pool. A provision known as the "belly-button tax" requires every company that provides insurance–big employers, organized labor, and insurance carriers—to pay a $63 levy on each person covered. That goes into a fund to compensate insurance carriers who end up paying big medical bills for new customers who buy on the government exchanges.

It's still in place, although the Obama administration has indicated it wants some of the entities that have to pay it this year to be let off in 2015 and 2016.

A third provision, known as risk adjustment, calls for insurers that end up with a healthier mix of participants to compensate those that end up with riskier members. This program is permanent but is less controversial because it doesn't call for any federal spending.

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RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225–2927
Minority (202) 225–3641

December 10, 2015

Ms. Julie McPeak
Commissioner of Commerce and Insurance
State of Tennessee
500 James Robertson Parkway
Nashville, TN 37243-0565

Dear Ms. McPeak:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Thursday, November 5, 2015, to testify at the hearing entitled "Examining the Costly Failures of Obamacare's CO-OP Insurance Loans."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Thursday, December 24, 2015. Your responses should be mailed to Dylan Vorbach, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to Dylan.Vorbach@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
500 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243-5065
615-741-6007

BILL HASLAM
GOVERNOR

JULIE MIX McPEAK
COMMISSIONER

Via E-Mail

December 21, 2015

Hon. Tim Murphy,
Chair, Subcommittee on Oversight and Investigations
U.S. House Committee on Energy and Commerce
Washington, DC 20510

Chairman Murphy:

Thank you again for the invitation to appear before the Subcommittee on Oversight and Investigations on Thursday, November 5, 2015, to testify at the hearing entitled "Examining the Costly Failures of Obamacare's CO-OP Insurance Loans." I enjoyed the opportunity to discuss the Tennessee Department of Commerce and Insurance's (TDCI) experience with Community Health Alliance (CHA) and our current efforts to runoff company operations. Please see the responses below to questions posed in your December 10, 2015 letter, separated by the individual requests.

The Honorable Tim Murphy

1. Ms. McPeak, you were instrumental in regulating the CO-OP so that premium prices were appropriate and consumers were protected.

    a. What problems did your state's CO-OP encounter that led to its closure?

    Response: *For CHA, and presumably other CO-OPs, to be viable over the long-term, successful first year operations were critical. Unfortunately, CHA experienced significant challenges in its first year of operations. CHA entered the Tennessee market solely with exclusive provider organization (EPO) plans offering no out-of-network benefits while other marketplace carriers offered broader preferred provider organization (PPO) plans which included out-of-network benefits. In addition, CHA plans were priced approximately 20 percent above the marketplace leader which lead to minimal membership in 2014. Those factors, plus a population that had the highest average risk score in the U.S. according to the U.S. Centers for Medicare and Medicaid Services (CMS), contributed to the company recording a net loss of approximately $22 Million at year-end 2014.*

CHA experienced further challenges in 2015 when its membership grew to more than 40,000 covered lives before TDCI and CMS froze CHA enrollment on January 15, 2015. In September and October of 2015, CMS first announced its intent to place CHA on a corrective action plan (CAP) and on an enhanced oversight plan (EOP). Subsequently, on October 5, CMS released information that made it clear that the inability of the Risk Corridor Program to be fully funded would create a net worth deficiency for CHA that could not ultimately be cured.

b. Does your state's CO-OP have enough money to support consumers and pay its claims through the end of the year? If no, then how will claims be paid?

Response: *TDCI continues to work with CMS and CHA representatives to run off company operations. At this time, we believe that CHA has enough money to pay all claims incurred through December 31, 2015.*

c. What was the CO-OP's projected enrollment? Did they reach it?

Response: *CHA projected to reach between 22,000 and 30,000 enrollees in 2015. At their highest enrollment in 2015 before the enrollment freeze, the company had over 40,000 enrollees. For the remainder of 2015, they have around 25,000 current enrollees.*

2. CMS converted solvency loans to start-up loans in seven CO-OPs, so the loans would artificially appear more financially secure.

a. Did CMS approach you about converting solvency loans as start-up loans so the CO-OP would appear to have more capital on the books?

Response: *CMS released guidance entitled "Amending CO-OP Loans Agreement to Apply Surplus Notes to Start-up Loans" on July 9, 2015. That guidance was made available to CO-OPs across the country and CHA executives referenced the conversion guidance in several conversations with TDCI staff through October 2015. CMS did not formally approach TDCI to request that we approve a conversion.*

b. If yes, do you believe it makes sense to convert the loans? Why?

Response: *The Department made very clear to CHA executives that we would not approve any startup loan conversion unless that conversion was done bilaterally between CMS and CHA at which point Statutory Accounting Principles would require the loan money to be classified as surplus.*

c. What problem would converting the loans solve?

Response: *N/A*

3. CMS has created "enhanced oversight plans" as a measure to evaluate troubled CO-OPs.

   a. Did CMS place your CO-OP under an enhanced oversight plan?

      Response: *Yes. On September 29, 2015, CMS wrote to CHA announcing its intent to place CHA on a corrective action plan (CAP) and on an EOP.*

   b. If yes, explain what the "oversight plan" entailed.

      Response: *The EOP, which was attached as an exhibit to my written testimony, included several reporting requirements, such as progress updates on enrollment projects, complaints, claims, and company financial information.*

   c. Did the "oversight plan" conflict with other guidance or feedback from CMS?

      Response: *TDCI is not aware of the EOP conflicting with other CMS guidance.*

The Honorable Marsha Blackburn

1. Ms. McPeak, during the hearing you estimated that CMS enrollment projections for the TN CO-OP were between twelve and fifteen thousand in its first year, growing to around twenty thousand in 2015. What projection were you given for 2016 enrollment?

   Response: *In phone calls with CHA executives, TDCI officials were told that the company needed enrollment of at least 23,000 in 2016 to remain viable.*

I hope these responses assist in your review of the CO-OP Program. Your staff is welcome to coordinate any future follow up through Michael Humphreys, my Assistant Commissioner for Insurance, at Michael.humphreys@tn.gov.

Sincerely,

[redacted]

Commissioner

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225–2927
Minority (202) 225–3641

December 10, 2015

Mr. James J. Donelon
Commissioner of Insurance
State of Louisiana
P.O. Box 94214
Baton Rouge, LA 70804

Dear Mr. Donelon:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Thursday, November 5, 2015, to testify at the hearing entitled "Examining the Costly Failures of Obamacare's CO-OP Insurance Loans."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Thursday, December 24, 2015. Your responses should be mailed to Dylan Vorbach, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to Dylan.Vorbach@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

LOUISIANA DEPARTMENT OF INSURANCE
JAMES J. DONELON
COMMISSIONER

December 23, 2015

The Honorable Tim Murphy
Chairman
Subcommittee on Oversight and Investigations
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

Dear Congressman Murphy:

Please find attached hereto my answers to additional questions submitted in the Congressional Record following the hearing of your Subcommittee on November 5, 2015 regarding the Co-Op Loan Program created by the Affordable Care Act. First, let me begin by explaining my request to you at the time of my appearance for permission to leave the meeting following the second round of testimony by myself and my fellow witnesses. As I explained at that time, my flight departure was fast approaching and I was anxious to return to Louisiana for business purposes but questioned the decision to ask permission to depart prior to adjournment when upon my return home that evening was questioned by my wife about the appropriateness of my request. She had seen the meeting on C-Span earlier that evening.

In hindsight I acknowledge that it was not appropriate for me to do so and I regret the precedent I set with that request and apologize for any breach of congressional protocol it represented. Be assured that I am happy to answer any follow up questions any member has concerning the failure of the Louisiana Health Co-Op and am pleased to be able to help in that regard with the attached responses. Additionally, I will happily respond to any follow up questions you or the other members have concerning the circumstances leading to the failure of our Co-Op and would also be happy to make my staff available to yours for any follow up information needed by your committee. Again, I regret the early departure and hope that it did not result in a burden to the committee or its staff as you pursue the important issues presented by the failure of Co-Ops across the country.

With best wishes and kindest personal regards, I remain

[redacted]

P. O. BOX 94214 • BATON ROUGE, LOUISIANA 70804-9214
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Attachment - Additional Questions for the Record

The Honorable Tim Murphy

1. Mr. Donelon, you were instrumental in regulating the CO-OPs so that premium prices were appropriate and consumers were protected.

    a. What problems did your state's CO-OP encounter that led to its closure?
    b. Does your state's CO-OP have enough money to support consumers and pay its claims through the end of the year?
    c. If no, then how will claims be paid?
    d. What was the CO-OP's projected enrollment? Did they reach it?

2. CMS converted solvency loans to start-up loans in seven CO-OPs, so the loans would artificially appear more financially secure.

    a. Did CMS approach you about converting solvency loans as start-up loans so the CO-OP would appear to have more capital on the books?
    b. If yes, do you believe it makes sense to convert the loans? Why?
    c. What problem would converting the loans solve?

3. CMS has created "enhanced oversight plans" as a measure to evaluate troubled CO-OPs.

    a. Did CMS place your CO-OP under an enhanced oversight plan?
    b. If yes, explain what the "oversight plan" entailed.

4. Mr. Donelon has said that over $9 million in solvency loans has been reserved to pay outstanding claims to providers that served customers in the CO-OPs. CMS required the CO-OP to change leadership before authorizing the spending of the $9.25 million.

    a. Did the Louisiana CO-OP receive its federal loans in one lump sum or were they allotted in increments?
    b. Did CMS have a say in how each increment was spent?
    c. Did CMS reserve federal funds to be spent only on claims to providers?
    d. How much money? What were the conditions?

5. In your testimony, you write that the Louisiana CO-OP made decisions that could hurt consumers.

    a. Is it true that the Louisiana CO-OP missed the 90 day notice requirement, and gave its enrollees only a week to pick a new health insurance plan?
    b. Can you explain how that hurts consumers?
    c. Is that an example of poor leadership within the CO-OP?
    d. The Louisiana Health CO-OP is not backed by a guaranty fund, so if the CO-OP cannot pay its claims, enrollees and mostly providers will be stuck with unpaid bills. How will this affect consumers and providers? Who is to blame – the CO-OP or CMS?

Additional Questions for the Record

The Honorable Tim Murphy

1. **Mr. Donelon, you were instrumental in regulating the CO-OPs so that premium prices were appropriate and consumers were protected.**
   a. **What problems did your state's CO-OP encounter that led to its closure?**
   The Co-Op had numerous operational and organizational problems from its inception. We are still in the process of determining the full extent of the Co-Op's operational problems. Once the Co-Op was placed into receivership, it was clear that the Co-Op was unprepared for the nature of the individual health insurance market, which has caused a multitude of problems including: failing to give enrollees timely notice of premium statements, in some cases the failure entirely to bill enrollees for premiums due, the failure to adequately and timely provide prior authorizations for requested services, the failure to adequately and timely process, adjudicate and pay claims which resulted in the Co-Op paying statutorily-required interest to providers, and failure to provide notices of termination under Louisiana law. Furthermore, although the rates for the Co-Op's products appeared to be reasonable upon review by actuaries, the underlying assumptions regarding enrollment failed to materialize. As a result, the Co-Op's loss ratio was unsustainable, which also partly resulted from poor medical management and utilization.
   b. **Does your state's CO-OP have enough money to support consumers and pay its claims through the end of the year?**
   Yes, the La Co-Op will have enough funds to pay claims through the end of the year for those claims we expect to receive before year-end. We are in the process of recalculating claims in accordance with a recent order of the court which provides a reduced obligation. The calculated results are as yet unknown, but we are hopeful the adjustments, when coupled with asset recoveries, will allow us to pay all provider claims. Co-Op enrollees will be covered for services with their providers through December 31.
   c. **If no, then how will claims be paid?**
   d. **What was the CO-OP's projected enrollment? Did the reach it?**
   Enrollment was project by Co-Op management at 28,000 for 2014, 38,000 for 2015 and 44,000 for 2016. The Co-Op never reached their projections in 2014 or 2015. Enrollment reached a high of 16,262 in April 2015 and is currently 10,366.

2. **CMS converted solvency loans to start-up loans in seven CO-OPs, so the loans would artificially appear more financially secure.**
   a. **Did CMS approach you about converting solvency loans to start-up loans so the CO-OP would appear to have more capital on the books?**
   The conversion referenced in this question was not an appropriate option for the Louisiana Co-Op because at the time that conversions were occurring, it was already clear that the Louisiana Co-Op would not survive.

b. If yes, do you believe it makes sense to convert the loans? Why?
c. What problem would converting the loans solve?
Since the La. Co-Op's loans were not converted, I cannot predict what may have resulted from the conversion, if anything.

3. **CMS has created "enhance oversight plans" as a measure to evaluate troubled CO-OPs.**
   a. Did CMS place your CO-OP under an enhanced oversight plan?
   Yes, we are aware that CMS had placed the Co-Op under stringent reporting time frames for voluminous types of information and that various milestones were included in this corrective action plan.
   b. If yes, explain what the oversight plan entailed.
   The Louisiana Department of Insurance did not influence or consult on the CMS-initiated plan. I would urge you to inquire with CMS for any specific corrective action plans for the Co-Ops collectively or individually. I am willing and more than happy to coordinate the transmittal of copies of the oversight plan from the Co-Op's receiver to you. However, those documents are not within the possession of the Department of Insurance.

4. **Mr. Donleon has said that over $9 million in solvency loans has been reserved to pay outstanding claims to providers that served customers in the CO-OPs. CMS required the CO-OP to change leadership before authorizing the spending of the $9.25 million.**
   a. Did the Louisiana CO-OP receive its federal loans in one lump sum or were they allotted in increments?
   Yes, the Co-Op received its final solvency loan of $9,263,798 on November 27, 2015. Below is a chart of both solvency loans and start-up loans received by the Co-Op.

Start-up Loans ~ $13,176,560

$ 4,344,050.00	10/12/2012
$ 1,937,800.00	12/28/2012
$ 1,408,270.00	3/22/2013
$ 1,738,340.00	6/21/2013
$ 2,375,986.00	9/20/2013
$ 612,114.00	12/20/2013
$ 10,000.00	1/4/2014
$ 740,000.00	1/4/2014
$ 5,000.00	3/20/2014
$ 5,000.00	6/20/2014

Solvency Loans ~ $52,614,100

$	10,690,120.00	3/28/2013
$	4,726,440.00	6/14/2013
$	750,000.00	12/27/2013
$	27,183,742.00	3/27/2014
$	9,263,798.00	11/27/2015

b. Did CMS have any say in how each increment was spent?
The loan agreements have restrictions on how funds are spent:

Solvency Loan Restrictions

Section 5. SOLVENCY FINANCING-BASE PROVISIONS

5. 1. Use

Solvency Loan Funds must only be used to establish Risk-Based Capital Reserves to be held by Borrower and other capital reserves necessary to meet State Reserve Requirements and other State Insurance Laws, and then only in strict accordance with the Business Plan and Disbursement Plan. Borrower must notify Lender in writing if Borrower determines that its expenses have exceeded its premium revenue for three consecutive months, which notice shall be delivered within 30 calendar days of such determination.

Start-up Loan Restrictions

Section 4. START -UP LOAN -BASE PROVISIONS

4.1. Use

Start-Up Loan Funds must only be used in accordance with the Business Plan. the Start-Up Loan Disbursement Plan and the CO-OP FOA. Start-Up Loan Funds cannot be used to pay for costs associated with purchase of land and construction of facilities, including construction or clinical costs such as the costs of actual medical services provider salaries and contracts or payment, provider clinical space, and clinical equipment.

c. Did CMS reserve federal funds to be spent only on claims to providers?
No additional restrictions are known other than those in the loan documents referred to above.

d. How much money? What were the conditions?
See subpart c above.

5. **In your testimony, you write that the Louisiana CO-OP made decisions that could hurt consumers.**
   a. Is it true that the Louisiana CO-OP missed the 90 day notice requirement, and gave its enrollees only a week to pick a new health insurance plan?

Yes, this is true. It occurred when the Co-Op failed to meet the requirement for coverage that was to be renewed on January 1, 2015.

b. Can you explain how that hurts consumers?

In order for a consumer to have coverage with an effective date of January 1, a consumer must enroll in a health plan and pay the first month's premium by December 15. When consumers receive notice from the Co-Op on December 7 that their plans will be discontinued on January 1, and that they must therefore pick a new plan for coverage on January 1, a consumer thereby has only between December 7 and December 15 to pick an entirely new health plan. Both state and federal law included a 90 day notice for plan discontinuation precisely to avoid these situations so that consumers can have a reasonable amount of time to comb through the details of health plans without being rushed into a decision.

c. Is that an example of poor leadership within the CO-OP?

It was an obvious mistake that I believe was the result of the many challenges faced by start-up insurers working within short time frames. Certainly, the leadership made the mistake but it also was obviously not intentional.

d. The Louisiana Health CO-OP is not backed by a guaranty fund, so if the CO-OP cannot pay its claims, enrollees and mostly providers will be stuck with unpaid bills. How will this affect consumers and providers? Who is to blame—the CO-OP or CMS?

It will affect consumers and providers precisely as stated in the question—some bills, which are the legal obligation of the Co-Op, may go unpaid or paid at a reduced amount. With respect to apportioning blame, it is the fault of an insurer of any kind when it fails to satisfy its legal obligations. CMS has no say in nor any role in the liquidation of insurance companies as it is entirely the purview of states. Some states require guaranty fund contributions and therefore coverage by HMOs and some states do not. Louisiana does not, partly at the urging of existing insurers in the state who do not want to subsidize poorly capitalized, start-up competitors, which is true in many other states.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

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Minority (202) 225-3641

December 10, 2015

Dr. Mandy Cohen
Chief of Staff
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Dr. Cohen:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Thursday, November 5, 2015, to testify at the hearing entitled "Examining the Costly Failures of Obamacare's CO-OP Insurance Loans."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Thursday, December 24, 2015. Your responses should be mailed to Dylan Vorbach, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to Dylan.Vorbach@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

Mandy Cohen's Hearing
"Examining the Costly Failures of Obamacare's Co-Op Insurance Loan"
Before
Energy & Commerce O&I Subcommittee

November 5, 2015

Attachment - Additional Questions for the Record

The Honorable Chris Collins

1. **Dr. Cohen, during the hearing you asserted that, despite its $35 million loss in 2014, a further investment in the New York co-op was warranted. What analysis did your office use to arrive at this conclusion? Please provide any CMS analysis conducted in relation to the continued investment in the New York co-op.**

Answer: CMS undertook a rigorous review process before awarding additional solvency funding. This included both an external and internal review by subject matter experts of updated business plans, feasibility studies, programmatic and regulatory compliance, actuarial soundness, and financial statements. The enrollment, claims, and financial data available during the review of applications for additional solvency loan funding was limited in scope. CO-OPs had six to nine months of enrollment data and claims experience upon which CMS could base its review for additional solvency funding. CO-OPs were in their initial stages of operation and a substantial number of CO-OP members enrolled on or after the January 1, 2014, coverage start date, as open enrollment for 2014 coverage did not end until March 31, 2014. Only this limited data was available because of the late enrollment and the length of time it takes to receive, process, and pay claims, and for those claims to mature to have actuarial meaning.

The Honorable Larry Bucshon

1. **In the interest of assessing the accountability of the process behind CMS funds allocation, who in the organization was responsible for signing the state loan agreements?**

Answer: All the original CO-OP loan agreements were signed by the Deputy Director of the Center for Consumer Information and Insurance Oversight. All amendments obligating additional funds have been signed by either the Director of the Center, or a Deputy Director.

2. **Is it correct that CMS intended from the outset for the state co-op loan program to be budget-neutral?**

Answer: Section 1322 of the Affordable Care Act established the CO-OP program and provided funding to eligible entities to help establish and maintain these new issuers. CMS has

implemented the program as required by statute and with funds available. Section 1322 (b)(3) requires the repayment of start-up loans within five years and solvency loans within 15 years. While the Affordable Care Act appropriated $6 billion for the program, the Congress made a number of substantial rescissions to that initial funding level. The Department of Defense and Full Year Continuing Appropriations Act, 2011, rescinded $2.2 billion; the Consolidated Appropriations Act, 2012, rescinded an additional $400 million; and the American Taxpayer Relief Act of 2012 further reduced the remaining $3.4 billion of CO-OP funding by rescinding 90 percent of funds unobligated as of the date of enactment. Finally, an additional $13 million was reduced due to sequester in Fiscal Year 2013. Ultimately, the CO-OP program awarded approximately $2.5 billion to 24 qualifying entities out of an initial pool of 147 applicants.

○